Managed Care Unit

INDIANA HEALTH COVERAGE PROGRAMS

Managed Care Operating Procedures Manual

LIBRARY REFERENCE NUMBER: MC10001
REVISION DATE: APRIL 2002
VERSION 2.0

Library Reference Number: MC10001

Document Management System Reference: Managed Care Operating Procedures Manual MC10001

Address any comments concerning the contents of this manual to:

EDS Managed Care Unit
950 North Meridian Street, 10th Floor
Indianapolis, IN 46204
Fax: (317) 488-5169

Revision History

Document Version Number	Revision Date	Revision Page Number(s)	Reason for Revisions	Revisions Completed By
Version 1.0	January 2002	All	New manual	Karen Girgis
Version 2.0	April 2002	All	Quarterly Update	Publications

Table of Contents

Revision History iii

Section 1: Introduction 1-1
Overview 1-1

Section 2: Managed Care Unit Overview 2-1
Managed Care Unit Mission 2-1
Managed Care Unit Vision 2-1
External 2-1
Internal 2-1
Managed Care Unit Goals 2-1
Communication 2-1
Responsiveness 2-1
Customer Service Orientation 2-2
Approach 2-2
Managed Care Unit Organization and Staffing 2-2
Position Descriptions 2-2
Managed Care Team 2-3
Organizational Chart 2-4
Managed Care Unit Meetings 2-4
Managed Care Unit-Facilitated Meetings 2-4
Managed Care Unit Internal Operation 2-7

Section 3: Hoosier Healthwise Program Operations - General 3-1
Program Goals 3-1
Program Participants 3-1
Fiscal Agent 3-1
OMPP 3-1
Enrollment Broker 3-2
Managed Care Organizations 3-2
Medical Policy and Surveillance and Utilization Review Contractor 3-2
Contract Monitor 3-2
CHIP Office 3-2
Hoosier Healthwise Program Policy Development 3-3
Member Eligibility in Hoosier Healthwise 3-3
Mandatory MCO Enrollment 3-5
Managed Care Aid Categories 3-5
IHCP Enrollees Ineligible for Managed Care 3-6
Provider Enrollment in Hoosier Healthwise 3-6
IHCP Requirements 3-7
Hoosier Healthwise PMP Eligibility 3-7
PrimeStep Enrollment 3-8

MCO Network Enrollment 3-8
PMP Service Locations 3-9
Network Changes 3-9
Open Network Changes 3-9
Panel Size 3-9
PMP Education 3-10
PMP Disenrollment 3-10
Coordination 3-11
Interfaces withing EDS 3-11
Provider Enrollment 3-11
Client Services Provider Representatives 3-11
Finance Unit 3-12
Systems 3-12
Forms 3-12

Section 4: Hoosier Healthwise Program Operations - PrimeStep (PCCM) 4-1
Prime*Step* Overview 4-1
Covered Services 4-1
Billing/Payment 4-1
Self-Referral Services 4-2
Provider Participation 4-2
Eligibility 4-2
PMP Enrollment 4-3
PMP Disenrollment 4-3
Interfaces with Program Contractors 4-3
PMP Listing (Enrollment Broker) 4-3
PMP Assignments and Potential Recipients Tapes (Enrollment Broker) 4-4
IHCP Dental Listing (Enrollment Broker) 4-4
Monthly Reports 4-4
PMP Administrative Fee Payments 4-5
Purpose 4-5
Distribution 4-5
Quality Monitoring 4-5
Recoupment/Adjustment 4-5
PMP Certification Codes 4-6
Purpose 4-6
Initial Certification Code 4-6
Ongoing Certification Codes 4-6
Certification Code Monitoring 4-7
Issue Resolution 4-7
PMP Refusal to Give Certification Code 4-8
Interfaces with PMPs 4-8
PMP Enrollment Rosters 4-8
Interfaces within EDS 4-9

Claims 4-9
Other Interfaces within EDS 4-11

Section 5: Hoosier Healthwise Program Operations - MCO (RBMC) 5-1
Risk-Based Managed Care Overview 5-1
Program Participants 5-1
OMPP and the CHIP Office 5-1
Fiscal Agent 5-1
Enrollment Broker 5-2
MCO Contract Monitor 5-2
MCO Enrollment 5-2
Enrollment Authorization 5-2
MCO Contract Regions 5-2
Enrollment Request 5-3
Enrollment Processing 5-5
Quality Control 5-5
Updates to MCO Enrollment Information 5-5
MCO Orientation 5-5
Updates to MCO Materials 5-6
MCO Disenrollment 5-6
MCO Subcontractors 5-6
Authorization 5-7
Coordination Plan 5-7
MCO Network Participation 5-7
Eligibility 5-8
PMP Certification Codes and Plan Changes 5-8
Interfaces with MCO Contractors 5-8
MCO Enrollment Rosters 5-8
MCO Capitation Payments 5-9
MCO Delivery Capitation Payments 5-12
Adjustments to Capitation 5-13
Third Party Liability Reporting 5-15
IHCP Provider Enrollment Report 5-15
Interfaces with PMPs 5-16
MCO PMP Enrollment Roster 5-16
Shadow Claims 5-17
Purpose 5-17
Submission 5-17
Region 22 5-17
MCO-Denied Claims 5-18
Compound Prescription Drug Claim Submission 5-18
Elements Unique to Shadow Claims 5-18
Delivery Capitation Payments 5-19
Shadow Claims Edits and Audits 5-20
Precycle Edits 5-20

Claim Resolution Edits/Audits 5-20
Duplicate/Potentially Duplicate Claims 5-21
Shadow Claims Output Documents 5-22
Self-referral Services 5-25
Emergency Care 5-26
Family Planning 5-26
Chiropractic 5-26
Podiatry 5-27
Vision Care 5-27
HIV/AIDS Care Coordination 5-27
Diabetes Self-management Training 5-28
Carved-out Services 5-28
Behavioral Health 5-28
Dental 5-29
School Corporation 5-29
Services Related to Self-referral and Carved-out Services 5-29
Interfaces within EDS 5-30
Provider Enrollment 5-30
Client Services 5-30
Systems 5-30

Section 6: PMP Disenrollment from Hoosier Healthwise 6-1
Overview 6-1
Purpose 6-1
Disenrollment Types 6-1
Outcomes 6-1
Disenrollment Requests 6-2
PMP Disenrollment Processing Procedures—Internal 6-2
Checklist 6-5
Windows 6-6
PMP Disenrollment Policy—Historical Perspective 6-6
Original Disenrollment Logic 6-6
Updated Disenrollment Logic 6-6
Hoosier Healthwise PMP Disenrollment Forms and System-generated Letters 6-6
PMP Disenrollment Checklist 6-6
Letter to Member of Disenrolled PrimeStep/PCCM PMP 6-17
Letter to Member Confirming New PMP/MCO and PCCM 6-18
PMP Disenrollment/MCO Member Letter 6-19
Letters to PMP/MCO PMP Disenrollment 6-20

Section 7: Hoosier Healthwise Children's Health Insurance Program Operations 7-1
Program Overview 7-1
Member Eligibility for Phase II CHIP Enrollees 7-2
Enrollment for Phase II CHIP Enrollees 7-2

Retroactive Eligibility 7-3
Provider Eligibility 7-3
Benefit Packages 7-3
Limitations 7-3
Exclusions 7-4
Enrollment Rosters 7-4
Capitation Payments 7-5
Administrative Fee Payments 7-5

Section 8: Auto-assignment and Member Enrollment and Disenrollment 8-1
Auto-assignment 8-1
Policy 8-1
Timing 8-1
Flowcharts 8-1
System Logic 8-5
Special Characteristics of Auto-assignment 8-8
IndianaAIM Auto-assignment Start/Stop Reason Codes 8-9
Member Assignment 8-12
Eligibility Re determination 8-12
Member Request to Change PMP 8-12
Provider-Initiated Requests for Member Reassignment 8-13
Unacceptable Reasons for PMP-Initiated Member Transfer Requests 8-14
Member Lock-In 8-14
Member Disenrollment from Hoosier Healthwise 8-15
Monitoring and Quality Control 8-18
Eligible vs. Enrolled Report 8-18

Section 9: MCO Orientation 9-1
Overview 9-1

Section 10: Quality Improvement 10-1
Overview 10-1
Processes 10-1
Statistical Process Control Methods/Process Behavior Charts 10-1
Key Measures 10-5
Potential Improvement Logs 10-7
Standard Formats for Agendas/Minutes 10-8
Agenda Items 10-9
Action Items 10-9

Section 11: Project Management 11-1
Overview 11-1
Processes and Procedures 11-1
Unit Task List 11-1

CSR Monitoring 11-2
CSR Development 11-2
Project Task Plans 11-4

Section 12: Reports 12-1
Overview 12-1
Quality Control Monitoring Reports 12-1
Managed Care Issue and Trend Monitoring 12-1
Managed Care Edit Monitoring 12-1
Hoosier Healthwise Process Behavior – QI Data Grid Control Charting 12-2
Ad hoc Reports 12-3
15th of the Month Report 12-3
Eligible vs. Enrolled Report (Package A and B) 12-6
Managed Care TPL Report 12-11
Newborn Preselect Report 12-15
Eligible vs. Enrolled Report (Package C) 12-18
PMP Enrollment Report 12-22
QI Data Grid Report 12-29
ITEM 12-34
Shadow Graph Reports 12-35
Top 10 Shadow Claim Denial Reports 12-38
System-generated Reports 12-41

Appendix A: File/Tape/Report/Letter - Tracking Table A-1

Appendix B: Managed Care Policy Meeting Agenda Item Request Form B-1

Appendix C: Certification Code Tracking Referral Form C-1

Appendix D: Certification Code Recovery Letter D-1

Appendix E: Information for Researching Certification Code Issues E-1

Appendix F: Project Task Plan Mask F-1

Appendix G: Internal Provider Accounts Receivable Form G-1

Glossary Gl-1

Index I-1

Section 1: Introduction

Overview

The *Managed Care Unit Operating Procedures Manual* documents the policies, processes, and procedures in place to support the operations of the Hoosier Healthwise Managed Care Program. In addition, this manual describes the interfaces with the Office of Medicaid Policy and Planning (OMPP) and other program contractors, interfaces with other EDS units, reporting requirements, and quality assurance measures in these sections:

The *Managed Care Unit Overview* contains the Managed Care Unit's mission and vision statements, organizational chart, unit position descriptions, and meetings the Managed Care Unit regularly facilitates or attends.

The *Hoosier Healthwise Program Operations—General* contains program goals, a description of other Hoosier Healthwise program contractors and their responsibilities, and a description of the Managed Care Unit role in program policy development.

The *Hoosier Healthwise Program Operations—PrimeStep (PCCM)* section contains a description of the Primary Care Case Management (PCCM) option in the Hoosier Healthwise program and the interfaces required to support this program component.

The *Hoosier Healthwise Program Operations—MCO (RBMC)* section contains a description of the Risk-Based Managed Care (RBMC) option in the Hoosier Healthwise program and the interfaces required to support this program component.

The *PMP Disenrollment from Hoosier Healthwise* section contains details about the disenrollment process and the implications it has for members, providers, and networks.

The *Hoosier Healthwise Children's Health Insurance Program (CHIP) Operations* section contains an overview of the expansion to the Indiana Health Coverage Programs (IHCP) created by the *Balanced Budget Act of 1997* and the interfaces required to support this program.

The *Auto-assignment* section provides an overview of the auto-assignment process; describes the logic contained in Indiana*AIM* to

support the process; and describes the monitoring/quality control processes that ensure accuracy.

The *Quality Improvement* section contains the quality initiatives and ongoing processes developed and implemented to ensure consistency and to measure the results of the Managed Care Unit operations.

The *Project Management* section describes the Managed Care Unit processes in place that ensure accurate, timely, and consistent results from unit projects.

The *Reports* section contains report definitions and procedures for report production for both system-generated and ad hoc reporting produced in the Managed Care Unit.

Section 2: Managed Care Unit Overview

Managed Care Unit Mission

The Managed Care Unit's mission is to support the Hoosier Healthwise Managed Care Program with quality data, analysis, and proactive pursuit of issue identification and resolution.

Managed Care Unit Vision

External

The Managed Care Unit provides enhanced data analysis and reporting; proactively develops Hoosier Healthwise Managed Care Program policy; fosters improved communication between and among all Hoosier Healthwise Program participants; provides timely, accurate customer support and service; provides utilization review for Hoosier Healthwise Programs; partners with systems to foster appropriate, accurate system enhancements in a timely manner; and leads the integration of Hoosier Healthwise into the entire account's daily operations.

Internal

The Managed Care Unit has a spirit of efficient teamwork that emphasizes good communication, cooperation, support, and quality processes that enhance performance.

Managed Care Unit Goals

Communication

Work with customers (internal and external) to set expectations, evaluate progress of work, seek informal feedback, and provide written summaries of meetings that accurately document action items.

Responsiveness

Respond to requests made of the Managed Care Unit with accurate, timely, and thorough information.

Customer Service Orientation

Anticipate the needs of the customer, Hoosier Healthwise providers and members, and other program entities in a spirit of cooperation and teamwork.

Approach

Offer proactive, creative, and permanent solutions to problems; continually seek to improve quality, service, and results.

Managed Care Unit Organization and Staffing

Position Descriptions

The following text provides an overview of the positions that comprise the Managed Care Unit.

Managed Care Director

This leadership position manages the daily activities of the Managed Care Unit. The unit consists of four Managed Care specialists, one Managed Care enrollment/disenrollment coordinator, and one Managed Care reporting specialist. The director performs liaison functions with business policy units and managed care contractors. The director also coordinates and communicates with stakeholders and works closely with the customer to ensure that the unit's contractual obligations are met. The director also coordinates managed care activities with other contractors in the managed care program, including MCOs and the enrollment broker, to communicate and resolve program issues.

Managed Care Specialist

This position is responsible for the functional operation of the Indiana Title XIX Managed Care program, including coordination activities with the OMPP and its various program contractors. The Managed Care specialist identifies, researches, and resolves Managed Care program issues; and serves as liaison between the Managed Care Unit and other units within the account and outside the account on Managed Care issues. Job tasks include the following:

- PMP enrollment/disenrollment functions
- CSR test design, test process, and post implementation review
- Member eligibility
- Managed Care capitation functions
- Policy development

- Manual writing and revisions for the *Managed Care Policy and Procedures Manual* and the *Managed Care Unit Operating Procedures Manual*.
- Quality management.

Enrollment/Disenrollment Coordinator

The enrollment/disenrollment coordinator is responsible for all aspects of the Hoosier Healthwise Managed Care Program provider enrollments and disenrollments. This includes, but is not limited to, continually training the Managed Care entities on enrollment and disenrollment processes and procedures, assignment of enrollment requests using the Document Tracking System (DTS), tracking and logging of disenrollments, processing panel change requests, and monthly reporting of enrollment and disenrollment issues as well as quantifying the requests.

Reporting Specialist

The reporting specialist is responsible for all aspects of Managed Care reporting including report design, documentation, verification, training, and report distribution. The reporting specialist also serves as the primary liaison for Managed Care reports for the OMPP, its contractors, and internally within the account.

Managed Care Team

The Managed Care team members are cross trained to perform and support the functions of more than one position. In addition, the entire team is trained and capable of performing the following tasks:

- Complete system change requests for Indiana*AIM* modifications related to Managed Care operations
- Conduct quality review of shadow claims, Managed Care reports, and other Managed Care communication
- Perform data analysis of Managed Care operations
- Resolve and analyze Managed Care operational, policy, and system issues

Organizational Chart

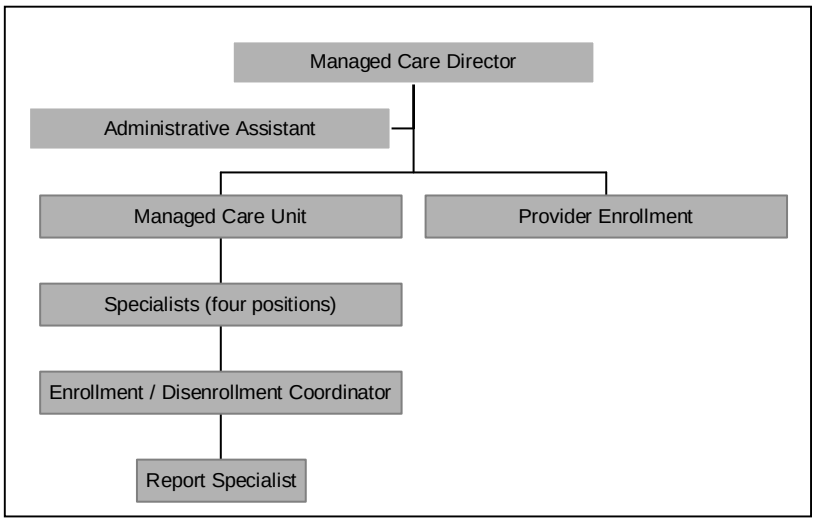


Figure 2.1 – Managed Care Unit Organizational Chart

Managed Care Unit Meetings

Managed Care Unit-Facilitated Meetings

The EDS Managed Care Unit is responsible for facilitation of the following monthly meetings for the Hoosier Healthwise program:

- Managed Care Policy and Operations Meeting
- MCO Technical Meeting

Managed Care Policy and Operations

The ***Managed Care Policy and Operations Meeting*** is held the second Thursday of each month to provide a forum for discussion of new Hoosier Healthwise Managed Care Program policy and clarification of existing policy. The following participants are included:

- OMPP Managed Care director and staff
- EDS Managed Care director and staff
- Enrollment broker provider and member services representatives
- MCOs
- MCO subcontractors as identified by contracted MCOs
- Health Care Excel (medical policy contractor)

- Representatives from other State agencies or organizations as identified by the OMPP

These meetings focus on policy issues affecting implementation and operation of the Hoosier Healthwise Managed Care Program. EDS prepares the agenda from requests submitted by any of the meeting participants. Agenda item requests are submitted to the Managed Care Unit on a *Managed Care Policy Meeting Agenda Item Request Form* located at *L:\ManageCare\Managed Care Unitnit\Agendas\Mcmonth\agenitm.doc* (see *Appendix B: Managed Care Policy Meeting Agenda Item Request Form*) one week and one day prior to the Agenda Preparation meeting with the OMPP. EDS is also responsible for taking and distributing the minutes to all attendees of the meeting, as well as other EDS and OMPP staff.

In addition to the meeting facilitation, the Managed Care Unit prepares the agenda and has it approved by the OMPP in an Agenda Preparation meeting approximately two weeks prior to the meeting date. The agenda includes attachments pertinent to the agenda topics for review by participants prior to the meeting. It is distributed one week prior to the meeting date. The Managed Care Unit also writes and distributes minutes after each meeting. *Appendix B: Managed Care Monthly Meeting Agenda Item Submission* contains the meeting structure, agenda topic submission format, and meeting schedule.

MCO Technical Meeting

EDS facilitates a monthly meeting on the third Friday of each month to address technical issues of concern to the MCOs. This meeting is a central forum for discussion of issues relating to data exchanges between the MCOs and the fiscal agent. Participants include representatives from the following list:

- MCO technical staff and subcontractor staff as designated by the MCO and the OMPP
- EDS Managed Care Unit staff
- OMPP Managed Care staff
- Other technical staff or subject matter experts (SMEs) as required

Examples of issues discussed in this meeting include the following:

- Questions about the transmission or receipt of enrollment or capitation rosters
- Acceptance of shadow claims data into Indiana*AIM* or other electronic interfaces

The purpose of this meeting is to provide assistance to MCOs that identify issues needing clarification. Agenda items for this meeting

must be submitted to EDS one week prior to the meeting. Occasionally, the fiscal agent or the OMPP may identify issues to be addressed in this forum.

OMPP/EDS Status

The EDS Managed Care director facilitates the monthly OMPP/EDS status meeting on the second and fourth Tuesday of each month. The OMPP Managed Care director and staff, as well as EDS/Managed Care Unit staff, regularly participate in the meeting. Review of the Managed Care Unit task list is a standing item on the agenda prepared by the EDS Managed Care director. This meeting is also used as a forum to discuss potential or ongoing matters pertinent to the Hoosier Healthwise program operations and policy. EDS prepares and distributes minutes after each meeting.

Meeting Documentation

All meetings facilitated by EDS are documented on standard meeting agenda and minutes templates on *L:\Manage Care\Managed Care Unitnit\Agendas/* or *L:\ManageCare\Managed Care Unitnit\Minutes* using the meeting name with a **.doc** file extension in a **month day year** format (for example, 08_13_00).

Managed Care Unit Participation

Representatives from the Managed Care Unit regularly attend and participate in several other meetings that affect the operations or policy for the Hoosier Healthwise Managed Care Program.

Managed Care Status

Representatives from the enrollment broker, EDS, and the OMPP meet biweekly to discuss operational and policy issues related to the Managed Care program. EDS and the enrollment broker submit agenda items to the OMPP. The OMPP is responsible for finalizing the agenda, facilitating the meeting, and documenting the minutes. The Agenda Preparation meeting for the Managed Care Policy and Operations meeting is held with the OMPP on the first meeting day of the month (one week prior to the Managed Care Policy and Operations meeting) immediately following the Managed Care status meeting.

Quality Improvement Committee

The Quality Improvement Committee's (QIC) function is to provide oversight for the appropriateness and quality of care provided to members of the Hoosier Healthwise Managed Care networks by establishing standards and guidelines for the provision of care. The QIC serves as the coordinating and advisory body. It is responsible for integrating the quality improvement process. The committee meets monthly according to the schedule established by OMPP and the contract monitor, Tucker Alan, Inc. Meeting participants include Managed Care staff from the OMPP, EDS, and staff representatives from all of the managed care entities. Tucker Alan, Inc., facilitates this meeting. The agenda and previous month's meeting minutes are mailed to the Managed Care Unit team member responsible for attending.

Focus Study Workgroup	The Focus Study Workgroup's function is to develop and review study designs that provide quantitative data for determining if quality standards are being met or exceeded. The managed care entity contract monitor facilitates the monthly meeting. The meeting agenda and previous month's meeting minutes are e-mailed to the Managed Care Unit team member responsible for attending.
Clinical Advisory Committee	The Clinical Advisory Committee (CAC) was established by the OMPP and is comprised of participating primary medical providers (PMPs) enrolled in the Hoosier Healthwise Managed Care Program. Participation includes representatives from the PCCM MCO delivery systems, as well as representatives from the Indiana Department of Health. The CAC's mission is to advise the OMPP concerning its policies by State-contracted MCOs making recommendations that support the quality, accessibility, appropriateness, and cost effectiveness of health and medical care provided to Indiana's Hoosier Healthwise Managed Care members. The enrollment broker facilitates this meeting on the third Thursday of every other month. The agenda and previous month's meeting minutes are mailed to the Managed Care Unit team member responsible for attending.
Communication	Managed Care Unit attendees summarize the above meetings at the team meeting held each week.
Managed Care Unit Reference Library	Historical and current information pertinent to the operation of the Managed Care Unit is in the unit's bookcases and filing cabinets, as well as electronic back-up versions of vital documents. Diskettes are stored in the Managed Care Director's office and current, working documents are stored in the *L:\managed care\Managed Care Unitnit* directory of the local area network.

Managed Care Unit Internal Operation

Managed Care Unit Team Meeting	The Managed Care Unit meets each week to discuss the status of operational issues pertinent to the fiscal agent responsibilities for the Hoosier Healthwise program. Quality improvement initiatives and measures are also discussed. Standing agenda items include the following: • Status of the issues on the unit task list (every other week) • Reports from other meetings attended by Managed Care Unit staff • Roundtable—miscellaneous matters of interest to the Managed Care Unit

Other potential or ongoing matters pertinent to Hoosier Healthwise program policy and operations are covered. The meeting is facilitated by Managed Care Unit team members on a rotating schedule and minutes are taken. On an alternating weekly basis, when Unit Task List items are reviewed, the Plano Managed Care Systems team joins the meeting, via speakerphone.

Monthly One-on-One

Each month the Managed Care Unit director meets individually with each member of the Managed Care Unit staff to discuss projects and other matters relevant to individual performance objectives, as well as the individual contribution to the team.

Section 3: Hoosier Healthwise Program Operations - General

Program Goals

The managed care component of the Hoosier Healthwise program is designed to meet the following goals:

- Ensure access to primary and preventive care
- Improve access to all necessary health care services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

Program Participants

The following text briefly describes the roles of the various participants responsible for the administration of the Hoosier Healthwise Managed Care Program. The Managed Care Unit has key contact people identified within each organization to resolve any operational issues that arise.

Fiscal Agent

EDS is the fiscal agent for the IHCP, including the Hoosier Healthwise Managed Care Program, and is responsible for all matters related to the development, maintenance, and operation of Indiana*AIM*. Major responsibilities include provider enrollment, claim adjudication, and payment to providers, based on the program in which the provider's members are enrolled. EDS also generates monthly capitation payments and semi monthly enrollment rosters to the MCOs and semi-PMPs in both the Prime*Step* and MCO networks.

OMPP

The OMPP is the office within Indiana Family and Social Services Administration (IFSSA) that administers the IHCP, including Hoosier Healthwise. The OMPP has the final responsibility for all program policies and coordination with other state and federal agencies as required.

Enrollment Broker

Lifemark Corporation is the enrollment broker for the OMPP. In addition to the administration of the Prime*Step* network, the enrollment broker serves as an unbiased source of member education about all aspects of the Hoosier Healthwise Managed Care Program, facilitation of initial member enrollment into the program, member-initiated PMP changes, and member disenrollment.

Managed Care Organizations

MCOs are lawful entities authorized to operate a prepaid health care delivery plan (such as an HMO) on a capitated basis that arranges, administers, and pays for the delivery of health care services to members as designated by the OMPP.

Medical Policy and Surveillance and Utilization Review Contractor

Health Care Excel (HCE), Inc. is responsible for medical policy development for the IHCP. HCE assists in the development of medical policy for all IHCP fee-for-service components, administers prior authorization, and identifies potential overuse or fraudulent activity of program participants. MCOs contact HCE with questions about IHCP medical policy issues.

Contract Monitor

Tucker Alan, Inc., monitors MCO activity and performance to ensure compliance with contract standards. The monitoring contractor also monitors the quality of care provided to members by all managed care entities.

CHIP Office

The Office of the Children's Health Insurance Program (CHIP) is the office within the IFSSA that administers the phase two expansion of the IHCP as described in *Section 7: Hoosier Healthwise Children's Health Insurance Program Operations* in the *IHCP Provider Manual*. The CHIP office has the final responsibility for all policies and coordination with other State and federal agencies for this program.

Hoosier Healthwise Program Policy Development

OMPP may ask Managed Care Unit staff to assist in the research and development of a policy for the Hoosier Healthwise program. The Managed Care Unit manager assigns the project to a Managed Care Unit staff member. The policy is drafted and documented in the standard formats located in *L:\managedcare\ Managed Care Unitnit\policy*. The Managed Care Unit staff member presents the draft policy at the Managed Care Policy and Operations meeting for input from the MCOs and enrollment broker and revises the policy until it receives the OMPP approval and signature.

Member Eligibility in Hoosier Healthwise

> *Note: Section 8: Auto-assignment and Member Enrollment and Disenrollment details Unit processes associated with Hoosier Healthwise membership.*

Caseworkers in the Division of Families and Children (DFC) office in the county where the member resides are responsible for eligibility determination and enrollment of IHCP members. This includes updating member eligibility and personal data for continuing enrollees at periodic eligibility redeterminations. This data is entered by the county caseworkers into the online Indiana Client Eligibility System (ICES). Indiana contracts with Deloitte & Touche for the administration and maintenance of ICES.

Potential Hoosier Healthwise managed care members can also enroll in various enrollment centers in hospitals, clinics, schools, and other outreach locations throughout Indiana. Enrollment center personnel assist potential members with applications and forward them to the DFC offices for processing.

EDS, as the fiscal agent, receives ICES enrollee eligibility update tapes that interface daily with Indiana*AIM*. Enrollee data retained in Indiana*AIM* confirms eligibility for the various IHCP programs, including Hoosier Healthwise managed care, during claims processing. Enrollee eligibility data can be viewed via Indiana*AIM* online windows. However, any changes to the data are completed by county caseworkers and updated by receipt of the daily ICES tapes.

Lifemark, the enrollment broker, enrolls eligible members into Hoosier Healthwise managed care by establishing a link between an eligible member and a Hoosier Healthwise PMP in the Indiana*AIM* online

windows. The State retains the sole responsibility for the maintenance of the general IHCP eligibility or aid category to which the member is assigned.

The OMPP is responsible for identification of members eligible for enrollment in Hoosier Healthwise based on broad aid categories established by ICES. Enrollment in Hoosier Healthwise is mandatory for most IHCP enrollees who are eligible for the program. The following groups of IHCP enrollees are eligible for enrollment in the Prime*Step* or MCO components of the program in various benefit packages:

- **Package A (Standard plan)** covers children, low-income families, some pregnant women, and the disabled and chronically ill
- **Package B (Pregnancy coverage)** covers pregnant women for pregnancy-related and postpartum care, urgent care, family planning, pharmacy, and transportation services
- **Package C (Children's health plan)** covers children younger than 19 years old in families with incomes from 150 to 200 percent of the federal poverty level (FPL) for preventive, primary, and acute care
- **Package D (Hoosier Healthwise for Persons with Disabilities and Chronic Illnesses)** covered disabled and chronically ill as certified by the OMPP's Medical Review Team (MRT) process. This managed care plan was discontinued December 31, 1999, and its members were moved into Traditional Medicaid Package A.
- **Package E (Emergency care)** covers emergency care only for certain people, otherwise ineligible for IHCP, such as those who are in the country without lawful papers from the Immigration and Naturalization Service (INS)

Enrollment in a managed care plan is for Hoosier Healthwise members in the following broadly defined categories:

- **Temporary Assistance for Needy** Families (TANF) includes caretakers and children younger than 18 years old who meet eligibility requirements
- **Pregnancy Medicaid** includes pregnant women who do not receive TANF. The full scope of benefits is available to women who meet strict income and resource criteria. Pregnancy-related coverage is provided to women whose income is below 150 percent of the FPL without regard to resources.

- **Children's Medicaid** includes children whose families do not receive TANF, but who are younger than 21 years old and meet the eligibility requirements.
- **Children's Health Insurance Program (Phase I expansion)** effective July 1, 1998, includes children ages zero to 19 years old in families with income up to 150 percent of the FPL who are uninsured and otherwise ineligible for IHCP benefits.

Mandatory MCO Enrollment

As established in *Public Law 291-2001, Section 160 (IC 12-15-12-14),* Hoosier Healthwise Managed Care members in certain Indiana counties with populations between 150,000 and 700,000 are required to enroll with an MCO plan. While Marion County's population is greater than 700,000, mandatory MCO enrollment in Marion County is not prohibited, and is directed by OMPP. Beginning in early 2002, current (at that time) Prime*Step* Hoosier Healthwise members in the identified counties were transitioned from PCCM into enrollment with a local MCO in the RBMC delivery system. The transition dates, by county, from Prime*Step* to an MCO are listed in Table 3.1.

Table 3.1 County Transition Dates

Counties	Transition Date
Allen and Marion	April 2002
Elkhart and St. Joseph	July 2002
Lake, Vanderburgh	October 2002

Managed Care Aid Categories

Participation in a managed care plan is mandatory for the following aid categories: MA2, MA9, K2 10, MAC, MAE, MAF, MAM, MAN, MAT, MAU, MAX, MAY, and MAZ. Participation in a managed care plan is **voluntary** for members in MA3 and MA4 (wards and foster children) aid categories.

Participation in Hoosier Healthwise is **voluntary** for people in the K2 10 (CHIP Phase 2) category, but once enrolled, members are **required** to enroll in a managed care plan; therefore, participation in a managed care plan is mandatory. **CHIP (Phase 2 expansion – Package C)** effective January 1, 2000, includes children ages zero through 19 years old in families with income from 150 to 200 percent of the FPL who are uninsured and otherwise ineligible for IHCP benefits. Unlike other

categories of eligibility in Hoosier Healthwise, continued eligibility in Package C is dependent upon payment of monthly premiums.

IHCP Enrollees Ineligible for Managed Care

Some subcategories of IHCP enrollees are not eligible for the Hoosier Healthwise Managed Care Program even though they are enrolled in an otherwise eligible aid category. Some examples of these groups include the following:

- Hoosier Healthwise members who move out of Indiana, even though they may retain IHCP eligibility while residing outside the State
- Undocumented workers who are eligible for limited benefits in the IHCP
- Hoosier Healthwise members who become eligible for Medicare
- Hoosier Healthwise members who become eligible for long term care
- Hoosier Healthwise members who become eligible for IHCP hospice care
- Hoosier Healthwise members who elect to participate in a Home and Community Based Waiver (HCBW) program
- Members of federally-recognized American Indian tribes
- Other members and potential members as determined by the OMPP

Hoosier Healthwise members in these subgroups are disenrolled from the managed care program when they are identified. The Managed Care Unit produces monthly reports that identify potentially ineligible members for the enrollment broker who reviews the eligibility and enters disenrollments in Indiana*AIM* as needed.

The State has sole authority for determining whether families or individuals meet any of the eligibility criteria and, therefore, are eligible to enroll in or disenroll from the Hoosier Healthwise program.

Provider Enrollment in Hoosier Healthwise

The following is an overview of the provider enrollment process for the IHCP as it applies to Hoosier Healthwise.

IHCP Requirements

To participate as a PMP or specialist in the Hoosier Healthwise program, a provider must be enrolled as a provider of service in the IHCP. A provider is enrolled in the IHCP when all of the following conditions are met:

- The provider is duly licensed, registered, or certified by the appropriate professional regulatory agency pursuant to Indiana or federal law, or otherwise authorized by the IFSSA
- The provider has completed, signed, and returned an IHCP provider agreement and any such forms as required by the IHCP
- The provider has been assigned an IHCP provider number

Managed care entities should advise potential PMPs to contact the EDS Provider Enrollment Unit for all information and materials about the IHCP enrollment process. IHCP enrollment forms are available on the Indiana Medicaid Web site. The managed care entities ensure that any network providers rendering services to members in the Hoosier Healthwise program are enrolled as IHCP providers. Initial enrollment is accomplished by completing the *IHCP Provider Agreement* and submitting it to the EDS Provider Enrollment Unit.

Detailed information about completion of the provider agreement is in the *IHCP Provider Manual* or the Web site at www.indianamedicaid.com. The EDS Customer Assistance Unit can be contacted at 1-800-577-1278 or (317) 655-3240, option 3, for questions about provider enrollment in the IHCP.

Once the IHCP enrollment is completed, providers can enroll as PMPs in the Hoosier Healthwise Managed Care Program.

Hoosier Healthwise PMP Eligibility

PMPs participate in the Hoosier Healthwise Managed Care Program if they are IHCP-enrolled in one of the specialties in Table 3.2 and if they complete a Hoosier Healthwise PMP addendum with their IHCP Provider Agreement.

Table 3.2 – Provider Specialty to Indiana*AIM* Specialty Code

Provider Specialty	Indiana*AIM* System Code
General Internist	344—specialty code
General Pediatrician	345—specialty code

(Continued)

Table 3.2 – Provider Specialty to Indiana*AIM* Specialty Code

Provider Specialty	Indiana*AIM* System Code
Family Practitioner	316—specialty code
General Practitioner	318—specialty code
Obstetrics/Gynecology	328—specialty code

PMPs enroll directly with the enrollment broker for the Prime*Step* network and with an MCO for their networks. PMPs are allowed to enroll in both Prime*Step* and with an MCO, although they may only be open for new member enrollment in one network at a time.

PrimeStep Enrollment

In addition to IHCP enrollment, PMPs who want to enroll in the Prime*Step* network must complete the *Primary Medical Provider Addendum* to the IHCP provider agreement. The completed *Primary Medical Provider Addendum* is submitted to the Prime*Step* network. The Prime*Step* network verifies that the information provided on the addendum is accurate and acceptable. Upon completion, the addendum is forwarded to the EDS Managed Care Unit with the enrollment cover form located on *L:\Manage Care\Managed Care Unitnit\Forms\PMP Enrollment\New Enrollment\ PrimeStep Enrollment, New.doc.*

The EDS Managed Care Unit receives the PMP addendum and enrollment cover form from the Prime*Step* network and enters the information in Indiana*AIM*.

MCO Network Enrollment

IHCP enrolled providers who wish to participate as PMPs in an MCO network must be enrolled in Indiana*AIM* in the specialties listed in Table 3.2. PMPs may be enrolled in only one MCO per region. MCOs enroll PMPs in their networks by submitting the PMP enrollment cover form located on *L:\ManageCare\Managed Care Unitnit\Forms\PMP Enrollment\(MCO name) Enrollment Form, New* and a copy of the PMP's contract signature page with a cover letter signed by a representative of the MCO network to the EDS Managed Care Unit. Linking the PMP to an MCO network is the only additional step required for PMP enrollment in Indiana*AIM*.

The physician-signed *PMP Update* form on *L:\Manage Care\Managed Care Unitnit\Forms\PMP Enrollment\Enrollment Update\(MCO Name) Enrollment Update.doc* must accompany the enrollment form for those

PMPs previously enrolled in the Prime*Step* network. MCOs must notify the OMPP, or its agent, of all PMPs enrolled in their networks.

PMP Service Locations

A provider must be IHCP enrolled at each service location where IHCP services are rendered. However, PMPs are limited to two service locations, regardless of the program for Hoosier Healthwise managed care member assignments. PMPs who wish to change service locations must submit a written request to the managed care entity with which they are enrolled. The managed care entity will complete the *PMP Enrollment Update* form on *L:\Manage Care\Managed Care Unitnit\Forms\PMP Enrollment\Enrollment Update\ (enter MCO name) Update Form.doc* and submit the request to the EDS Managed Care Unit who coordinates the service location change.

Network Changes

PMPs may prefer to have their managed care membership in one network and disenroll from one network (Prime*Step* or an MCO) to enroll in a different network. A physician-signed *PMP Network Change Request* form located on *L:\Manage Care\Managed Care Unitnit\Forms\PMP Enrollment \Enrollment Update\(enter managed care entity name), Update.doc* must accompany the *Network Enrollment* form for those PMPs previously or currently enrolled in a Hoosier Healthwise Managed Care Network.

Open Network Changes

A PMP within Hoosier Healthwise can change open networks from Prime*Step* to an MCO or vice versa. The request for this change is submitted by the managed care entity on the *PMP Open Network Change Request* form located on *L:\Manage Care\Managed Care Unitnit\Forms\PMP Enrollment\Open Network Change\PMP Open Network Change.doc.* Such changes are effective only at the beginning of a calendar quarter (a system change request is submitted to allow changes during any time of a calendar year). This change allows the PMP to keep members in the original network and accept new members in a different network.

Panel Size

PMPs are limited to a maximum panel size of 2,000 Hoosier Healthwise managed care members. The panel may contain a combination of

members from Prime*Step* network and one MCO network. Exceptions to the panel size maximum are granted only to allow the PMP to accept the following:

- Members who were previously assigned to the PMP's panel
- Family members of currently enrolled Hoosier Healthwise members
- Other members in designated provider shortage areas as determined by the OMPP

Panel Size Changes

All other requests for panel size over 2,000 must be submitted to the OMPP for approval. Once the OMPP approves the request for an increase in panel size over 2,000, it is forwarded to the Managed Care Unit at EDS for entry into the system. The OMPP has established a minimum allowable panel size of 150 Hoosier Healthwise managed care members to provide adequate PMP availability. Exceptions to the panel size minimum are also granted, with the OMPP's approval, for areas where a reduced panel size is needed to encourage provider participation.

Changes to a PMP's panel size are requested on the *PMP Panel Size/Hold Request* forms at the end of this section.

Panel Hold

It may be necessary to temporarily prevent new member assignments to a PMP's panel. Requests for a panel hold must be submitted by the PMP in writing to the managed care entity. The managed care entity completes and submits a *RBMC Network PMP Panel Size/Hold Request* or *the PCCM Network PMP Panel Size/Panel Hold Request* form to the EDS Provider Enrollment Unit for processing. These forms are shown at the end of this section. A panel hold is temporary and the managed care entity must determine the reason for the panel hold and the expected length of time the hold will be in effect.

PMP Education

Usually State-contracted provider outreach personnel assume responsibility for education of providers enrolled in the Prime*Step* network, and the MCOs educate their network providers. From time to time, State-contracted provider representatives from either the enrollment broker or EDS provide Hoosier Healthwise Managed Care Program information.

PMP Disenrollment

If a PMP disenrolls from Hoosier Healthwise or disenrolls as an IHCP provider entirely, managed care entities must ensure that members

continue to receive care while the disenrollment is pending or until another PMP is chosen or assigned to the members. Refer to Section *6: PMP Disenrollment from Hoosier Healthwise* for more information.

Coordination

Providers may submit information that affects their PMP status to the EDS Provider Enrollment Unit. If the information change causes the PMP to become ineligible to participate in Hoosier Healthwise, the EDS Provider Enrollment staff member notifies the PMP disenrollment coordinator in the Managed Care Unit. This change is not entered until the managed care staff is contacted and the PMP disenrollment process is complete. The managed care staff notifies the Provider Enrollment Unit when this change can be entered.

Interfaces withing EDS

Provider Enrollment

The EDS Provider Enrollment Unit is responsible for enrolling and disenrolling IHCP individual and group providers, as well as maintaining IHCP individual and group provider information. There are parts of these processes that require coordination between the Managed Care Unit and Provider Enrollment Unit to properly integrate. For example, when a request is made to disenroll a provider from a group, if the provider in the group is also a PMP with the group, the Provider Enrollment Unit must disenroll the PMP before the IHCP disenrollment can take place. When a provider enrolls with a group and also plans to enroll as a PMP with that group, the Provider Enrollment Unit notifies the Managed Care Unit when the group enrollment is complete in order for the Managed Care Unit to complete the PMP enrollment.

Client Services Provider Representatives

Members of the Client Services staff routinely contact the Managed Care Unit for assistance with matters that arise from phone calls, on-site visits, and written correspondence. The Managed Care Unit clarifies program policy matters or other issues related to the requests for assistance.

Finance Unit

The Finance Unit asks for assistance about where to redisposition administrative fee payments returned by providers. See deployment flowchart titled *ReturnedAdFee$_FIN_Managed Care Unit Deployment Process* in *I\QualityCI\flowcharts\mancare*.

Sometimes the Finance Unit receives provider payment intended for an MCO, either by live check from the mail or by the deposit report indicating a provider mailed MCO payment to the EDS lockbox. See deployment flowchart *Received MCO$_FIN_Managed Care Unit* in *I\Quality CI\flowcharts\mancare*.

Systems

The Managed Care Unit coordinates with the Systems Unit to provide input regarding Customer Service Request (CSR) high-level and detail requirements for any managed care CSR. The Managed Care Unit provides input to Systems staff regarding testing conditions and scenarios for Managed Care system changes. Please refer to the flowchart *Managed Care Unit&OPS Tape Deployment in I\Quality CI\flowcharts\mancare* for a view of tape creation and delivery activities between Operations and the Managed Care Unit.

Web Site

Additions and changes to the Managed Care-specific Web pages are coordinated with the Systems Web team, and go through a three-step process for promotion to the Production server. The Web team and the Managed Care analyst sequentially verify additions and changes in each of the three Web environments (development, test, and production). Once the Managed Care analyst has completed test environment verification, the OMPP is notified and asked to review and sign off on the addition or change, prior to Production implementation. Site addresses for the three environments are:

- Development http://dev.ihcp.inxix.sod.eds.com/
- Test http://test.ihcp.inxix.sod.eds.com/
- Production http://www.indianamedicaid.com/

Forms

Forms used in the PMP enrollment and update process are listed below and examples can be found on the following pages:

- Prime*Step* New Enrollment
- MCO New Enrollment

- Prime*Step* PMP Enrollment Update
- MCO PMP Enrollment Update
- PMP Open Network Change Request
- PMP Panel Size / Panel Hold Update

Indiana Health Coverage Programs

PRIMESTEP PRIMARY MEDICAL PROVIDER (PMP) ENROLLMENT COVER FORM – NEW ENROLLMENT

*Please complete every field on this form and submit to the **EDS Managed Care Unit**. You must submit all required documentations with this cover form. Incomplete forms and documentation will be returned to the submitter and will delay the PMP's enrollment. Note: A provider must first be enrolled in the Indiana Health Coverage Programs to enroll as a PMP.*

Date submitted to EDS _____ PrimeStep contact name _____

PrimeStep contact phone number _____ PrimeStep contact e-mail _____

A. Is the PMP disenrolling from one Managed Care Entity (MCE) to enroll into another MCE? Yes ☐ No ☐ Unknown ☐

B. Is the PMP enrolling into PCCM and also continuing enrollment in RBMC? Yes ☐ No ☐ Unknown ☐

1. Provider name: _____

2. A. Indiana Health Coverage Program provider number, must be nine digits _____

B. Indiana provider license number (if known/optional) _____

3. Please check the appropriate box to indicate whether the provider is enrolling as an individual or group PMP

Individual Enrollment ☐ Go to 5 Group Enrollment ☐ Go to 4

4. Group number and service location, must be nine digits plus an alpha suffix for the location _____ Go to 5

5. PMP may have two sites where Hoosier Healthwise members can be accepted. Please list one or two sites for the PMP.

A. First service location address, including county name, and daytime phone number

B. Second service location address, including county name and daytime phone number (if applicable)

6. Please indicate the PMP's specialty type: **Family Practitioner** ☐ **OB/GYN** ☐ **General Pediatrics** ☐ **General Practice** ☐ **General Internal Medicine** ☐

7. Hospital admitting privileges? Yes ☐ No ☐ Relationship privileges? Yes ☐ No ☐

8. Delivery privileges? Yes ☐ No ☐ Relationship privileges? Yes ☐ No ☐

9. Age restrictions (Please check one per service location)

Location 1	None	☐	0-2 years	☐	0-12 years	☐	0-17 years	☐	0-20 years	☐	13+ years ☐
	13-17 years	☐	13-20 years	☐	21+ years	☐	3+ years	☐	17+ years	☐	
Location 2	None	☐	0-2 years	☐	0-12 years	☐	0-17 years	☐	0-20 years	☐	13+ years ☐
	13-17 years	☐	13-20 years	☐	21+ years	☐	3+ years	☐	17+ years	☐	

10. Please indicate PMP scope of practice:

Families	Yes	☐	No ☐	**Obstetrics**	Yes	☐	No ☐
OB/GYN (OB only)	Yes	☐	No ☐	**All women (OB/GYN)**	Yes	☐	No ☐

11. Desired panel size, must be between 150 and 2000 unless otherwise approved by the OMPP _____

12. Desired effective date of enrollment _____

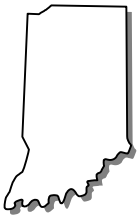
Comments:

To be completed by EDS Staff

Date received _____ Date completed _____ Completed by _____

Figure 3.1 – Prime*Step* PMP New Enrollment Form

Indiana Health Coverage Programs



[MCO NAME GOES HERE]

RBMC PRIMARY MEDICAL PROVIDER (PMP) ENROLLMENT COVER FORM – NEW ENROLLMENT

*Please complete every field on this form and submit to the **EDS Managed Care Unit**. You must submit all required documentation with this cover form. Incomplete forms and documentation will be returned to the submitter and will delay the PMP's enrollment. Note: A provider must first be enrolled in the Indiana Health Coverage Programs to enroll as a PMP.*

Date submitted to EDS _____ [MCO] contact name _____

[MCO] contact phone number _____ [MCO] contact e-mail _____

A. Is the PMP disenrolling from one Managed Care Entity (MCE) to enroll into another MCE? Yes ☐ No ☐ Unknown ☐

B. Is the PMP enrolling into RBMC and also continuing enrollment in PCCM? Yes ☐ No ☐ Unknown ☐

1. Provider name: _____

2. A. Indiana Health Coverage Program provider number, must be nine digits _____

   B. Indiana provider license number (if known/optional) _____

3. Please check the appropriate box to indicate whether the provider is enrolling as an individual or group PMP

   Individual Enrollment ☐ Go to 5 Group Enrollment ☐ Go to 4

4. Group number and service location, must be nine digits plus an alpha suffix for the location _____ Go to 5

5. PMP m ay have two sites where Hoosier Healthwise members can be accepted. Please list one or two sites for the PMP.

A. First service location address, including county name, and daytime phone number	B. Second service location address, including county name and daytime phone number (if applicable)

6. Please indicate the PMP's specialty type: **Family Practitioner** ☐ **OB/GYN** ☐ **General Pediatrics** ☐ **General Practice** ☐ **General Internal Medicine** ☐

7. Hospital admitting privileges? Yes ☐ No ☐ Relationship privileges? Yes ☐ No ☐

8. Delivery privileges? Yes ☐ No ☐ Relationship privileges? Yes ☐ No ☐

9. Age restrictions (Please check one per service location)

Location 1	None	☐	0-2 years	☐	0-12 years	☐	0-17 years	☐	0-20 years	☐	13+ years ☐
	13-17 years	☐	13-20 years	☐	21+ years	☐	3+ years	☐	17+ years	☐	
Location 2	None	☐	0-2 years	☐	0-12 years	☐	0-17 years	☐	0-20 years	☐	13+ years ☐
	13-17 years	☐	13-20 years	☐	21+ years	☐	3+ years	☐	17+ years	☐	

10. Please indicate PMP scope of practice:

Families	Yes	☐	No ☐	**Obstetrics**	Yes	☐	No ☐
OB/GYN (OB only)	Yes	☐	No ☐	**All women (OB/GYN)**	Yes	☐	No ☐

11. Desired panel size, must be between 150 and 2000 unless otherwise approved by the OMPP _____

12. Desired effective date of enrollment _____

Comments:

To be completed by EDS Staff

Date received _____ Date completed _____ Completed by _____

Figure 3.2 – MCO PMP New Enrollment Form

Indiana Health Coverage Programs

PRIMESTEP PRIMARY MEDICAL PROVIDER (PMP) ENROLLMENT COVER FORM – ENROLLMENT UPDATE

*Please complete every field on this form and submit to the **EDS Provider Enrollment Unit**. You must submit all required documentation with this cover form. Incomplete forms and documentation will be returned to the submitter and will delay the PMP's enrollment. Note: A provider must first be enrolled in the Indiana Health Coverage Programs to enroll as a PMP.*

Date submitted to EDS _____ PrimeStep contact name _____

PrimeStep contact phone number _____ PrimeStep contact e-mail _____

A. Is the PMP disenrolling from one Managed Care Entity (MCE) to enroll into another MCE? Yes ☐ No ☐ Unknown ☐

B. Is the PMP enrolling into PCCM and also continuing enrollment in RBMC? Yes ☐ No ☐ Unknown ☐

1. Provider name: _____

2. A. Indiana Health Coverage Program provider number, must be nine digits _____

   B. Indiana provider license number (if known/optional) _____

3. Please check the appropriate box to indicate whether the provider is enrolling as an individual or group PMP

   Individual Enrollment ☐ Go to 5 Group Enrollment ☐ Go to 4

4. Group number and service location, must be nine digits plus an alpha suffix for the location _____ Go to 5

5. PMP m ay have two sites where Hoosier Healthwise members can be accepted. Please list one or two sites for the PMP.

A. First service location address, including county name, and daytime phone number	B. Second service location address, including county name and daytime phone number (if applicable)

6. Please indicate the PMP's specialty type: **Family Practitioner** ☐ **OB/GYN** ☐ **General Pediatrics** ☐ **General Practice** ☐ **General Internal Medicine** ☐

7. Hospital admitting privileges? Yes ☐ No ☐ Relationship privileges? Yes ☐ No ☐

8. Delivery privileges? Yes ☐ No ☐ Relationship privileges? Yes ☐ No ☐

9. Age restrictions (Please check one per service location)

Location 1	None	☐	0-2 years	☐	0-12 years	☐	0-17 years	☐	0-20 years	☐	13+ years ☐
	13-17 years	☐	13-20 years	☐	21+ years	☐	3+ years	☐	17+ years	☐	
Location 2	None	☐	0-2 years	☐	0-12 years	☐	0-17 years	☐	0-20 years	☐	13+ years ☐
	13-17 years	☐	13-20 years	☐	21+ years	☐	3+ years	☐	17+ years	☐	

10. Please indicate PMP scope of practice:

Families	Yes	☐	No ☐	**Obstetrics**	Yes	☐	No ☐
OB/GYN (OB only)	Yes	☐	No ☐	**All women (OB/GYN)**	Yes	☐	No ☐

11. Desired panel size, must be between 150 and 2000 unless otherwise approved by the OMPP _____

12. Desired effective date of enrollment _____

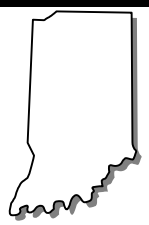
Comments:

To be completed by EDS Staff

Date received _____ Date completed _____ Completed by _____

Figure 3.3 – PrimeStep PMP Enrollment Update Form

Indiana Health Coverage Programs



[MCO NAME GOES HERE] RBMC PRIMARY MEDICAL PROVIDER (PMP) ENROLLMENT COVER FORM – ENROLLMENT UPDATE

*Please complete every field on this form and submit to the **EDS Provider Enrollment Unit**. You must submit all required documentations with this cover form. Incomplete forms and documentation will be returned to the submitter and will delay the PMP's enrollment. Note: A provider must first be enrolled in the Indiana Health Coverage Programs to enroll as a PMP.*

Date submitted to EDS _____ [MCO] contact name _____

[MCO] contact phone number _____ [MCO] contact e-mail _____

A. Is the PMP disenrolling from one Managed Care Entity (MCE) to enroll into another MCE? Yes ☐ No ☐ Unknown ☐

B. Is the PMP enrolling into RBMC and also continuing enrollment in PCCM? Yes ☐ No ☐ Unknown ☐

1. Provider name: _____

2. A. Indiana Health Coverage Program provider number, must be nine digits _____

B. Indiana provider license number (if known/optional) _____

3. Please check the appropriate box to indicate whether the provider is enrolling as an individual or group PMP

Individual Enrollment ☐ Go to 5 Group Enrollment ☐ Go to 4

4. Group number and service location, must be nine digits plus an alpha suffix for the location _____ Go to 5

5. PMP may have two sites where Hoosier Healthwise members can be accepted. Please list one or two sites for the PMP.

A. First service location address, including county name, and daytime phone number

_____

_____

_____

B. Second service location address, including county name and daytime phone number (if applicable)

_____

_____

_____

6. Please indicate the PMP's specialty type: **Family Practitioner** ☐ **OB/GYN** ☐ **General Pediatrics** ☐ **General Practice** ☐ **General Internal Medicine** ☐

7. Hospital admitting privileges? Yes ☐ No ☐ Relationship privileges? Yes ☐ No ☐

8. Delivery privileges? Yes ☐ No ☐ Relationship privileges? Yes ☐ No ☐

9. Age restrictions (Please check one per service location)

Location 1	None	☐	0-2 years	☐	0-12 years	☐	0-17 years	☐	0-20 years	☐	13+ years ☐
	13-17 years	☐	13-20 years	☐	21+ years	☐	3+ years	☐	17+ years	☐	
Location 2	None	☐	0-2 years	☐	0-12 years	☐	0-17 years	☐	0-20 years	☐	13+ years ☐
	13-17 years	☐	13-20 years	☐	21+ years	☐	3+ years	☐	17+ years	☐	

10. Please indicate PMP scope of practice:

Families	Yes	☐	No ☐	**Obstetrics**	Yes	☐	No ☐
OB/GYN (OB only)	Yes	☐	No ☐	**All women (OB/GYN)**	Yes	☐	No ☐

11. Desired panel size, must be between 150 and 2000 unless otherwise approved by the OMPP _____

12. Desired effective date of enrollment _____

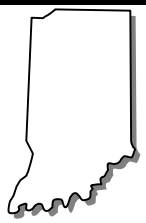
Comments:

To be completed by EDS Staff

Date received _____ Date completed _____ Completed by _____

Figure 3.4 – MCO PMP Enrollment Update Form

Indiana Health Coverage Programs



HOOSIER HEALTHWISE PRIMARY MEDICAL PROVIDER (PMP) OPEN NETWORK CHANGE COVER FORM - REQUEST

*Please complete every field on this form and submit to the **EDS Managed Care Unit**. You must submit all required documentation with this cover form. Incomplete forms and documentation will be returned to the submitter and will delay the PMP's open network change request.*

Note: Open network changes are to be used when a PMP is participating in both RBMC/PCCM networks and wishes to keep current member assignments in one network and accept new member assignments in another network (PMP is not disenrolling from current network enrollment).

Date submitted to EDS _____ MCE Requester: ☐ Lifemark

MCE contact name _____ ☐ MHS

MCE contact phone number _____ ☐ MDwise

MCE contact e-mail _____ ☐ Harmony

Provider name _____ IHCP Provider ID number *(Must be nine digits)* _____

If a rendering PMP, IHCP Provider Group ID number *(Must be nine digits)* _____

A. Current Network Enrollment: RBMC ☐ PCCM ☐ Effective end-date: _____

B. Requested Open Network Enrollment RBMC ☐ PCCM ☐ Effective date: _____

EDS Use Only

Date Received:	Date Request Processed:	Processor's Initials:

**Note*

A Primary Medical Provider (PMP) may change his/her 'open network' each quarter, but EDS must be notified one month prior to the beginning of the quarter (April 1st, July 1st, October 1st, or January 1st). For example: The PMP open network change request form must be submitted prior to March 1st for an April 1st effective date.

PMPs that have one active network enrollment in IndianaAIM and want to participate in both RBMC/PCCM networks, the MCE must submit a PMP open network change cover request form and a PMP network enrollment cover request form. The request forms must have a copy of the PrimeStep addendum for the PCCM network or a copy of the MCO PMP's contract signature page for the RBMC network attached.

Required attachments: The PMP's open network change request notification letter with PMP's signature.

Figure 3.5 – PMP Open Network Change Request Form

Indiana Health Coverage Programs

PRIMARY MEDICAL PROVIDER (PMP) PANEL SIZE/PANEL HOLD COVER FORM - UPDATE

*Please complete every field on this form and submit to the **EDS Managed Care Unit**. You must submit all required documentation with this cover form. Incomplete forms and documentation will be returned to the submitter and will delay the PMP's panel size update. Note: A panel size increase greater than the maximum 2,000 or a panel size decrease lower than the minimum 150 must have written OMPP approval.*

Date Submitted to EDS _____ MCE Requester: ☐ Lifemark

MCE contact name _____ ☐ MHS

MCE contact phone number _____ ☐ MDwise

MCE contact e-mail _____ ☐ Harmony

1. Provider Name _____

2. Indiana Health Coverage Program provider number, must be 9 digits _____

A. Panel Size Increase request? Yes ☐ Increase panel size to _____

B. Panel Size Decrease request? Yes ☐ Decrease panel size to _____

C. Panel Hold request? Yes ☐ Panel Hold effective date _____

D. Panel Hold Remove request? Yes ☐ Panel Remove effective date

OMPP Use Only (Request for panel size lower than 150 or greater than 2,000 must be approved by the OMPP Managed Care Director)

Approved Yes ☐ No ☐

"I authorize the above request for a panel size of _____ members."

OMPP Managed Care Director Name _____ Date Approved _____

Comments: _____

EDS Use Only

Date Received	Date Request Processed	Date QC'd

***Note**

***Panel Size Requests:** A PMP must choose to accept between 150 and 2000 Hoosier Healthwise members, with the exception of OB/GYN PMPs in rural counties who may decrease the limit to 50 (Panel size lower than the required 150 must be authorized by OMPP). The PMP must notify the MCE in writing of this request. If the PMP's current enrollment exceeds the new, reduced panel size, the panel size will not automatically decrease to the new desired size. Previous PMP and Case ID logic will continue to auto assign members to the PMP. However, no new members will be assigned. MCEs should be sure their PMPs understand this. Required documents: PMP Panel Size/Hold cover form-update, MCE PMP panel size request form (if applicable) and the PMPs signed letter of request.*

***Panel Hold Requests: A PMP may elect to temporarily freeze their panel to new enrollments. The PMP must notify the MCE in writing of this request. The PMPs signature letter request must indicate the effective date of the hold and document the reason for the request. The request is then forwarded to the EDS Managed Care Unit for processing. Please note that previous PMP and Case ID auto assignment logic override a panel hold status.** MCEs should be sure their PMPs understand this. Required documents: PMP Panel Size/Hold cover form-update, MCE PMP panel size request form (if applicable) and the PMP's signed letter of request.*

Figure 3.6 – PMP Panel Size / Panel Hold Update Form

Section 4: Hoosier Healthwise Program Operations - PrimeStep (PCCM)

Prime*Step* Overview

The Prime*Step* network operates as a fee-for-service health plan with a gatekeeper approach. Members in this network are linked to a PMP who acts as a gatekeeper by providing and arranging for most of the members' medical care. The PMP receives a per member, per month administration fee of $3, and is reimbursed on a fee-for-service basis for services rendered to the members. PMPs in the Prime*Step* network contract directly with Indiana through an addendum to the IHCP provider agreement.

Members linked to a PMP in the Prime*Step* network have access to all IHCP-enrolled providers for covered services. Those providers are then reimbursed on a fee-for-service basis.

Covered Services

Members in the Hoosier Healthwise Prime*Step* network are eligible for the same range of services as those in the traditional IHCP non-managed care plans. Covered services are listed in the *IHPC Provider Manual*. The significant difference from traditional fee-for-service coverage is that Prime*Step* members are linked to a PMP who provides or authorizes most medical care.

Billing/Payment

Providers who render services authorized by the PMP must document the authorization on their claim with the PMP's certification code and provider or license number. PMPs enrolled in Indiana*AIM* in the same billing group as the member's PMP may bill services rendered to the member without a PMP certification. The PMP certification code, described in detail further in this section, is valid for a specific calendar quarter. PMP-certified services that span a calendar quarter must be billed as separate claims. Specific billing instructions for PMP-certified services are in the *IHCP Provider Manual* in *Chapter 8: Billing*.

Self-Referral Services

Members may access some services from any IHCP-enrolled provider without PMP authorization. These are known as self-referral services and include services in the following broad categories:

- Dental
- Podiatry
- Chiropractic
- Behavioral health
- Diabetic self-management training
- Vision care (nonsurgical)
- Family planning
- Emergency care
- Pharmacy
- Transportation

In general, the services listed above bypass the requirement for PMP authorization in one of the following ways:

- Type/specialty of the rendering provider
- Procedure code
- Diagnosis code
- Combination of two of the above

For example, emergency services are identified by a group of diagnosis codes listed on a reference table in Indiana*AIM* and coded to bypass the requirement for PMP authorization. Other services, such as chiropractic and podiatric, bypass the PMP authorization based on the specialty of the rendering provider rather than on the procedure itself. An office visit rendered by a chiropractor or podiatrist does not require PMP authorization to pay, but the same procedure rendered by a different provider specialty denies without the PMP certification code.

Provider Participation

Eligibility

PMPs serve as gatekeepers who render or authorize ICHP-covered services to Hoosier Healthwise members on their panels. PMPs in the Prime*Step* network can refer their members to any IHCP-enrolled

provider or facility qualified to render the needed service. Additional information about the administration and policies for the Prime*Step* network are in the *Hoosier Healthwise PrimeStep PMP Provider Manual* produced by the enrollment broker and distributed to each new PMP at the time of enrollment in the program.

PMP Enrollment

The EDS Managed Care Unit is responsible for the PMP enrollment function. Providers wanting to enroll in the PrimeStep/PCCM network are required to complete an addendum to their IHCP provider agreement. The enrollment broker submits the PMP addendum to EDS along with a summary sheet. The Provider Enrollment specialist enters the managed care information in Indiana*AIM*.

Additionally, the Managed Care Unit maintains and updates other PMP information including panel size/panel hold requests, changes to PMP service locations, and address changes.

An overview of PMP Enrollment is located in the *Section 3: Hoosier Healthwise Program Operations—General* of this manual. Information about the managed care windows related to PMP enrollments is in the *Teleprocessing Users Guide-Managed Care*.

PMP Disenrollment

The Managed Care Unit is the contact point for PMP disenrollments from the Hoosier Healthwise Managed Care Program. Policies and procedures for PMP disenrollment are in *Section 6: PMP Disenrollment from Hoosier Healthwise*.

Interfaces with Program Contractors

PMP Listing (Enrollment Broker)

EDS produces an electronic listing of all active Hoosier Healthwise PMPs. The file is created the 20th of each month. Staff from the Systems Unit leaves the 8mm cartridge at the EDS front desk for pickup by Lifemark. See *L:\Manage Care\Managed Care Unitnit\tape spec* for the tape layout.

PMP Assignments and Potential Recipients Tapes (Enrollment Broker)

EDS produces an electronic listing of all active Hoosier Healthwise member PMP assignments and all potential managed care member PMP assignments. These files run on the 11th and 26th of each month. A System Operations Unit staff member then drops off the 8mm cartridge at the EDS front desk for pickup by the enrollment broker the first business day after the files run. See *L:\Manage Care\Managed Care Unitnit\tape spec*.

IHCP Dental Listing (Enrollment Broker)

The Managed Care Unit reporting specialist queries the *AIM* database on a quarterly basis to create a listing of all active Dental providers enrolled in the IHCP. Provider name, ID, address, county, and telephone number are reported. The listing is sorted by county, and is distributed to the Enrollment Broker, the PCCM Administrator, and to the OMPP.

Monthly Reports

The Managed Care Unit produces a series of monthly DSS ad hoc reports that are used to monitor enrollment in the Hoosier Healthwise managed care networks. When necessary, the enrollment broker manually completes disenrollments of Hoosier Healthwise members from the reports that include data on the following groups of enrollees:

- Undocumented Aliens
- Level of Care
- Out of State Members
- Wards/Foster Children

These reports are produced to identify Hoosier Healthwise members who may be inappropriately enrolled in a managed care network. The enrollment broker reviews potentially ineligible enrollees from the reports and disenrolls members as appropriate. Complete details regarding the schedules and production of these reports are in *Section 12: Reports*.

PMP Administrative Fee Payments

Purpose

Monthly case management fees of $3 are paid for every member actively assigned to a Prime*Step* PMP.

Distribution

Fees are generated automatically the third Wednesday of each month. The administrative fee cycle considers all members assigned to a PMP during that month and pays $3 per member, for members assigned to the PMP for any part of the month. For example, members with mid-month start dates or members with end dates other than the last day of the month generate $3 fees, as well as members with effective dates of the whole month.

Payment is issued to PMPs the Tuesday following the third Wednesday of the month along with other claims payment they may receive. The *Remittance Advice* includes a reference line for the total amount paid for administrative fees.

Fee listings are also generated on paper after the monthly administrative fee cycle and mailed to the PMP's **mail to** address. It lists the members for whom the PMP is receiving administrative payment. It is sorted alphabetically by the member's last name.

Quality Monitoring

Continual monitoring includes comparison of the Hoosier Healthwise administrative fee listings (CRLD report *MGD0003M*) to Prime*Step* PMP listings (CRLD report *MGD0005B*) and to Indiana*AIM* PMP assignment history screens.

Recoupment/Adjustment

The EDS Finance Unit uses the *Internal Provider Accounts Receivable* form to set up a manual accounts receivable (A/R) balance. This is an internal EDS form, a copy of which is in *Appendix G*. The following guidelines apply to the A/R:

- Either a provider (PMP) or EDS can initiate the creation of an A/R balance
- Accumulated fees can be set up for a lump sum and collected accordingly. For example, an A/R does not have to be established

for each $3 fee; a balance of $135 can be set up for recoupment of 45 members' administrative fees.

PMP Certification Codes

Purpose

Certification codes are assigned to each Hoosier Healthwise PMP enrolled in the Prime*Step* network. PMPs use the certification code to authorize specialty care or other medical services or equipment for Hoosier Healthwise members assigned to their panel. Most medical services must be rendered or authorized by the member's PMP to qualify for payment. Exceptions are noted for self-referral services listed in this section.

Initial Certification Code

The PMP Disenrollment and Enrollment coordinator in the EDS Managed Care Unit manually assigns a two-digit certification code as part of the PMP enrollment process. The entry of the code generates a letter to the PMP that provides the valid code for the remainder of the calendar quarter. Subsequent quarterly codes are generated as described in the following text.

Ongoing Certification Codes

Each PMP's initial certification code is manually assigned as part of the enrollment process. A start date and end date is entered according to the quarterly mailing schedule. New certification codes are given the current quarter's end date. However, if the entry date for the new certification code falls within three weeks of the scheduled system generated assignment, the end date must be the next quarter's end date. Thereafter, two-digit certification codes are randomly generated by Indiana*AIM* and may be comprised of either alphabetic or numeric characters. The EDS Operations Unit mails each PMP a quarterly, system-generated letter with an updated certification code that is valid for the following calendar quarter. The letters are mailed three weeks prior to the end of the current quarter. EDS uses 24 of the 26 letters of the alphabet and 1 through 9 of the numbers. The letters O and I, and the numbers 0 and 1 are not used. That means there are only **1,024 possible combinations** and since there are over 2,100 PMPs, some certification codes are repeated. Certification codes are not necessarily unique to each PMP.

Certification Code Monitoring

The Managed Care Unit monitors the certification code distribution process. All requests for provider certification code letters are entered on the unit's issue log. A quality monitoring process documents the number of system-generated certification code letters mailed to providers on a quarterly basis, and quantifies this count with the number of certification code issues logged. This measure allows trending of system issues related to the distribution of the letters. Once the data gathered suggests a trend for a specific provider, the procedure described in the following text assists in resolution.

Issue Resolution

The procedure for issue identification and resolution of the distribution process for PMP certification code letters is as follows:

1. Client Services telephone analysts verify the correct provider's service location address in Indiana*AIM*
   - If the provider is a PMP in a group, the group provider's service location address is where the certification code letters are sent
   - If the provider is an individual PMP, then the certification codes are sent to the individual service location
2. If the provider address is correct in Indiana*AIM*, the telephone analyst completes the Tracking/Referral slip and forwards to the Managed Care Unit for resolution. Incorrect address information is forwarded to the Provider Enrollment Unit for resolution.

Investigation Steps

1. Log issue on Managed Care Unit Tracking log
2. Contact the provider to determine if address information is correct
3. Determine frequency of occurrence – if unusually high, then steps 4-6 are performed:
4. Verify with EDS Operations that the print job was queued and run on time
5. Consult with a systems engineer (SE) if job was not queued
6. Try to identify probable cause

Resolution Process Steps

1. If probable cause was identified, determine the process for corrective action
2. Obtain the service location address from the provider
3. Provide the certification code to the provider. A certification code letter identifying the code can be faxed, e-mailed, mailed via U. S.

Postal Service, or the code may be provided by telephone (only Managed Care Unit staff member may provide by telephone).

A referral tracking slip is used for client telephone requests for certification codes from Prime*Step*/PCCM PMPs. Refer to *Appendix C: Certification Code Tracking Referral Form* for an example. This form is on *L:\Manage Care\Managed Care Unitnit\Cert Code\processes\Instructions for Tracking.doc*. As identified in the process steps listed above, the referral tracking form is completed and forwarded to the Managed Care Unit for resolution.

The final step in the resolution process is to provide the PMP with the certification code. This is accomplished by either sending the PMP the certification code in a recovery letter by mail or via fax, or by providing the code over the telephone. To provide the code over the telephone, the analyst must request the PMP's license number; this verifies it is the PMP requesting the code and not another provider. A copy of the recovery letter template is on the managed care's common drive at *Managed Care Unitnit\Cert Code\Letter Templates\recovrylet.doc* and in *Appendix D: Sample Recovery Letter*.

PMP Refusal to Give Certification Code

There may be instances when a PMP does not provide the certification code to authorize a service. Requests to override the PMP's decision may come to the Managed Care Unit from EDS Client Services who are the initial points of contact for many kinds of issues. EDS is not authorized to provide the PMP's certification codes, and in this instance refers callers to the enrollment broker's (Lifemark) Hoosier Healthwise Helpline at 1-800-889-9949.

Interfaces with PMPs

PMP Enrollment Rosters

Purpose

Twice monthly member enrollment rosters are sent to both MCO and PCCM PMPs to provide them with a list of the members assigned to their PMP panel.

Distribution

PMP member enrollment rosters are printed on paper the 11th and 26th of every month and mailed to the PMP's **pay to** address. The roster includes any new, continuing, or terminated panel members linked to each PMP's individual or group PMP affiliation. The new enrollee column includes new and re-determined members. The re-determined members are identified by their start date. The start date for re-

determined members is the first date the member was assigned to that PMP with new members having a more recent date. Groups receive rosters under their group name and provider number. The roster is sorted by the provider number of participating PMPs.

MGD0005B is the CRLD equivalent of *PCCM PMP Enrollment Rosters*. When searching the file on CRLD, the rosters are in provider number order, starting with individual PMP providers, then proceeding by group provider number. PMP members of groups are in provider number order under the group number.

Quality Control

Continual monitoring includes comparison of the Hoosier Healthwise administrative fee listings (CRLD report *MGD0003M*) to Prime*Step* PMP listings (CRLD report *MGD0005B*) and to Indiana*AIM* PMP assignment history screens.

Issue Resolution

Rosters can be reprinted from CRLD if a PMP did not receive the roster in the mail.

Interfaces within EDS

Claims

The Managed Care Unit may work with the EDS Claims Unit to resolve issues specific to Prime*Step* network claims. Providers in the Prime*Step* network bill claims for their members to EDS as fee-for-service claims. Most of the policy provisions, such as filing limits or claim submission formats that apply to traditional IHCP claims apply to Prime*Step* claims.

Edits/Audits

The following three claim edits are unique to Prime*Step* network claims:

- **1011—Recipient's PMP is Missing** is generated for claims that require, but do not contain, the PMP's IHCP provider number
- **342—PMP Certification Code Missing** is generated for claims that require, but do not contain, the PMP's certification code
- **343—PMP Certification Code Invalid** is generated for claims that have a certification code that is not valid for the dates of service on the claim

Information about these edits is located in the *Claims Resolutions Manual*.

Self-referral Procedures

As described previously in this section, members in the Prime*Step* network can access some services without the authorization of their PMP. Some of the self-referral services are identified in Indiana*AIM* by procedure code in the *Reference\Restrictions\Program to HCPC/PCCM* window.

> *Note: Other self-referral procedures may be identified by the type/specialty of the rendering provider, such as chiropractic/podiatric, and may not be visible in the reference file window.*

Reference File Maintenance

The Systems Account Services Unit maintains updates to the reference file. Any changes required to support the Prime*Step* network are coordinated with that unit.

Prior Authorization

Claims for members in the Prime*Step* network may be subject to Prior Authorization (PA) in addition to PMP Certification. OMPP's medical policy contractor (HCE) administers the IHCP PA function. Services requiring PA for traditional IHCP benefits also require PA for the Prime*Step* network.

Quality Control

The Managed Care Unit monitors the daily process behavior of Managed Care edits *342, 343, 1011, 2017,* and *2018,* by claim type. Reporting Managed Care edit activity includes process behavior charting, notation of exception indicators or process behavior (data) shifts, and research results. The Managed Care analyst reports occurrences of data shifts and exception points to the rest of the Managed Care team as soon as shifts or points are identified. The team may readily recognize that a *special cause* situation created the exception, or they may initiate further research to determine the cause. This type of data monitoring is expected to *red-flag* defects and breakdowns in upstream processes such as reference file updates and certain system changes.

Issue Resolution

Managed Care Unit staff coordinate Prime*Step* PA matters with the EDS Research Unit who meets regularly with the medical policy contractor. Other Prime*Step* claim matters are coordinated with Client Services or other EDS units who may identify issues with claim resolution for the network.

Other Interfaces within EDS

Other interfaces between the Prime*Step* Program entities and EDS occur, but are not exclusive to the Prime*Step* Program processes. These are described in *Section 3: Hoosier Healthwise Program Operations – General*, and include:

- Provider Enrollment
- Client Services Representatives
- Finance
- Systems

Section 5: Hoosier Healthwise Program Operations - MCO (RBMC)

Risk-Based Managed Care Overview

The State contracts with MCOs to provide medical services to Hoosier Healthwise program enrollees. Under a risk-based arrangement, the State pays the contracted MCO on a per member per month basis. This payment arrangement is known as *capitation* and is paid for every member enrolled in the MCO whether or not the member receives health care services during the month. In exchange for the monthly capitation payment, the MCO is responsible for managing and coordinating medical care and services for its enrollees.

In addition to the contracted MCOs, the following entities support the risk-based managed care (RBMC) component of the Hoosier Healthwise program.

Program Participants

OMPP and the CHIP Office

The CHIP office and the OMPP are the offices within the IFSSA that administer the IHCP, including Hoosier Healthwise. The OMPP and the CHIP office have the final responsibility for selecting and contracting with MCOs in a procurement process, as well as for the ongoing policy and administration functions. Both the OMPP and the CHIP office sign the MCO contracts.

Fiscal Agent

EDS is the fiscal agent for the IHCP, including Hoosier Healthwise, and is responsible for all matters related to the development, maintenance, and operation of Indiana*AIM*. The EDS Managed Care Unit supports the risk-based component of Hoosier Healthwise with adjudication of shadow/encounter claims, generation of enrollment rosters and capitation payments to MCOs and their PMPs, and facilitation of the monthly policy meeting for all Hoosier Healthwise contracting entities.

Enrollment Broker

Lifemark Corporation is the enrollment broker for the Hoosier Healthwise program. In addition to the administration of the Prime*Step* network, the enrollment broker serves as an unbiased source of member education about the Hoosier Healthwise Managed Care Program, facilitation of initial member enrollment into the program, member-initiated PMP changes, and member disenrollment.

MCO Contract Monitor

OMPP contracts with an MCO contract monitor whose job it is to ensure MCO contract compliance. The contract monitor is responsible for the facilitation of the monthly QIC meeting and the Focus study group as well as other meetings/activities designated by the OMPP. MCO contract monitor contracts are generally for two-year periods with options for extensions as defined by the OMPP in the request for proposal (RFP) that becomes the basis for the contract.

MCO Enrollment

Enrollment Authorization

The OMPP selects MCOs to serve the Hoosier Healthwise population through a competitive bidding process. Once contract negotiations are completed, the OMPP sends the Managed Care Unit written authorization to enroll the MCO. OMPP's authorization includes the following:

- Contract effective start and end dates
- Regions
- Negotiated capitation rates for each region
- Auto-assignment distribution percentage for each MCO and region

MCO Contract Regions

The OMPP negotiates separate contracts for each MCO. Contracts can be statewide, although capitation is based on regions. For example, one MCO may provide services in each of the three regions and would have three separate capitation rates specified for each region. The regions are identified in Indiana*AIM* with a nine-digit number followed by an alphabetic character (North, Central, South) to indicate

the region. The MCO identification number is randomly generated in Indiana*AIM* at the time of the MCO's initial enrollment.

Enrollment Request

Once approved by the OMPP, each contracted MCO submits an enrollment request to the Managed Care Unit for each region of Indiana where they are contracted. Table 5.1 illustrates the essential elements for enrollment:

Table 5.1 – Essential Elements for Enrollment

MCO Information
MCO region
MCO name (DBA name)—This name will appear on all Indiana*AIM* system references to the MCO
MCO address
MCO contact name
MCO contact phone numbers • *Corporate number* • *Member services number (used on EDS eligibility systems)*
Capitation Information
Capitation effective date
Capitation rates by category
Financial Information
IHCP Electronic Funds Transfer (EFT) form that includes the following: • *ABA number* • *EFT effective date* • *EFT end date* • *Account number* • *Account type*
Voided check
EFT information must be entered in Indiana*AIM* at least 18 days prior to the first scheduled capitation payment to allow time for the automatic test transfer procedure.
Contract Information
MCO effective date
MCO end date
MCO tax ID type
MCO tax ID number
Tax ID effective date
Tax ID end date
Update Authorization
Names, titles, phone numbers, and e-mail addresses of representatives in the organization who are authorized to change or update any of the elements contained in the original MCO enrollment information.

Enrollment Processing

EDS requests that the information in Table 5.1 be sent to the Managed Care Unit at least 30 days prior to the intended effective date of the MCO network. Once received, Managed Care Unit staff review the information for accuracy and complete the enrollment in the managed care windows in Indiana*AIM*. For details about the windows in this managed care subsystem, refer to the *Teleprocessing Users Guide-Managed Care*.

Quality Control

A Managed Care Unit staff member who has not processed the MCO enrollment verifies all entries into the MCO enrollment windows in Indiana*AIM*. If the MCO has submitted its negotiated capitation rates with its enrollment, the submitted rates are verified against those authorized by the OMPP.

The quality control process also includes verification of the review dates on the Managed Care Unit Outlook calendar.

The Managed Care Unit manager maintains paper copies of the enrollment request and all updates to the original information provided.

Updates to MCO Enrollment Information

Changes to information provided in the initial MCO enrollment are accepted only from authorized representatives of the MCO network as identified in the enrollment request. The Managed Care Unit manager designee will verify updates requested by MCO representatives other than those authorized.

MCO Orientation

All Hoosier Healthwise contracted managed care entities may be asked to participate in the orientation of a newly contracted Hoosier Healthwise MCO. EDS provides information requested by the OMPP that includes, but is not limited to, the following:

- *IHCP Provider Manual*
- *Electronic Claims Capture Manual*
- Sender IDs for electronic claim submissions
- *Claims Resolutions Manual*

- Pricing information and fee schedules
- File formats for capitation, TPL, and enrollment roster files
- Schedule and procedures for submission of test files for all electronic transmissions

Refer to *Section 9: MCO Orientation* for detailed information about the materials provided for this process.

Updates to MCO Materials

The Managed Care Unit provides updates to IHCP material for the MCOs. Most material is updated as needed or directed by the OMPP, rather than on a scheduled basis. Unless the updates are available on the www.indianamedicaid.com Web site, or unless directed otherwise, the materials are presented or discussed at the MCO Technical meetings.

MCO Disenrollment

Periodically, an MCO disenrolls from the Hoosier Healthwise program. MCO disenrollment reasons can include the following:

- An active MCO chooses not to participate in Hoosier Healthwise and does not participate in the reprocurement process at the end of the contract
- An active MCO is not selected during the reprocurement process
- An MCO ceases operation
- The OMPP terminates an MCO contract for any reason
- The State Department of Insurance terminates an MCO contract

The disenrollment affects the PMPs and members linked to the MCO in Indiana*AIM*. The Managed Care Unit procedures are dependent upon the amount of advance notice and the circumstances involved in the disenrollment. This section provides only basic considerations and requirements for the MCO disenrollment process.

MCO Subcontractors

MCOs are permitted, under the terms of their contract with the OMPP, to subcontract their services to large provider networks. The subcontracted network holds service contracts with PMPs, specialists, facilities, and ancillary providers. When an MCO ends a contract with

a large network subcontractor, the implications are similar to the disenrollment of a direct MCO contractor. The guidelines in this section may be considered for this scenario and for the disenrollment of an MCO.

Authorization

The OMPP must send the Managed Care Unit director written authorization to disenroll an MCO with the effective date of disenrollment. To appropriately coordinate the reassignment of both members and PMPs to other Hoosier Healthwise networks, this notification must be no less than 45 days prior to the effective end date.

Coordination Plan

The Managed Care Unit director or designated members from the Managed Care Unit staff develop a project task plan to coordinate all issues related to the disenrollment. The task plan includes, but is not limited to, these areas of concern:

- Communication–How and when will PMPs and members of the disenrolling MCO be notified
- PMP Disenrollment–Will PMPs from the disenrolling MCO join other Hoosier Healthwise networks? If so, the new network affiliations must be established in Indiana*AIM* prior to the effective date of member enrollment. If not, will they be enrolled in PCCM?
- Timing Issues–Indiana*AIM* functions must be considered in the MCO disenrollment plan. System processes, including PMP enrollment/disenrollment and auto-assignment, function within set time frames. It is important to ensure that there is no gap in member's Hoosier Healthwise enrollment during disenrollment of the MCO and the subsequent placement of PMPs and members into other networks.
- Quality Control–The MCO disenrollment task plan should include quality control reviews during the process to ensure all members are linked to new PMPs through self-selection of the auto-assignment process.

MCO Network Participation

Once an MCO is enrolled in Indiana*AIM*, the PMPs who participate in the network must be linked to the MCO in Indiana*AIM*. The

enrollment process is completed, documented, and confirmed by a Managed Care Unit enrollment specialist.

Eligibility

The general eligibility requirements for PMPs in any Hoosier Healthwise network are the same. The primary difference between PMPs who participate in the Prime*Step* network and those who participate in an MCO network is that MCO network providers are subject to a credentialing procedure before the enrollments are submitted to EDS for entry in Indiana*AIM*. An overview of the eligibility requirements is in *Section 3: Hoosier Healthwise Operations—General*.

The PMP Enrollment is submitted to and processed by the EDS Managed Care Unit. The process is the same as PMP enrollment into Prime*Step* except for the additional step to link the PMP to the MCO network.

PMP Certification Codes and Plan Changes

PMPs in an MCO network do not use the PMP certification code process in place for PMPs in the Prime*Step* network. PMPs who choose to remain active with Prime*Step*, but enroll with an MCO and only accept new members in the MCO network, continue to receive Indiana*AIM*-generated certification codes for the Prime*Step* members assigned during the PMP's enrollment with PrimeStep. If the PMP disenrolls from Prime*Step*, members are assigned to the MCO network and the generation of certification codes stops. See *Section 4: Hoosier Healthwise Operations—PrimeStep* for details on the PMP certification code process.

Interfaces with MCO Contractors

The Managed Care Unit interfaces with the MCOs contracted to provide services in the Hoosier Healthwise managed care plans as described in the following text.

MCO Enrollment Rosters

Purpose

MCO enrollment rosters provide twice a month listings of all the members assigned or terminated with an MCO/region for the time period reported.

Production Schedule

The jobs that create the enrollment rosters run the 11th and 26th each month. Files are then available for download from the Bulletin Board System (BBS) on the 12th and 27th of each month. Tapes are available the first business day after the rosters are created. EDS holds these tapes unless the MCO specifically requests distribution due to the MCO being unable to successfully retrieve the files from the BBS.

Distribution

Enrollment roster data files are accessible from the BBS by the MCOs when they use their ECS authorization number and password. Files are also copied on tape per MCO/region as a backup.

Quality Control

Continual monitoring includes comparison of the Hoosier Healthwise MCO enrollment rosters (CRLD report *MGD0004B*) to RBMC PMP enroll roster listings (CRLD report *MGD0034B*), MCO capitation listings (CRLD report *MGD0002M*), and to Indiana*AIM* PMP assignment history screens.

Issue Resolution

Historically, enrollment rosters were created and delivered after their targeted completion time. Pre-enrollment roster checks were developed in 1998 and continue to run against the data files to identify and resolve systematic eligibility issues, such as members no longer being in a managed care aid category or members losing IHCP eligibility. MCOs also experienced issues and delays when first downloading enrollment rosters from the BBS in early 1999. Upgrades to the BBS improved downloading capability and speed for the MCOs.

Reconciliation

Eligibility reconciliation files are created monthly on tape for the currently contracted MCOs. The SE queues these at the end of each month for Operations to create and deliver to the Managed Care Unit. The Managed Care Unit distributes the tapes to the designated MCOs. See the lower left instruction block on the deployment flowchart *Managed Care Unit and OPS Tape/cartridge Deployment Process* in *I\quality CI\flowcharts\mancare* for additional information on this.

MCO Capitation Payments

Purpose

MCOs are paid a per member per month fee for the management of care for members actively enrolled in their organization. This fee is paid whether or not the members receive health care services.

Rate Cells

The MCO contract periods for 1995 through 1996 calculated capitation payments based upon the member's eligibility aid category and their county's rural/urban designation. Since 1997, the member's age and sex have determined capitation categories. Currently age, sex, geographic region and Package A/B or Package C determine capitation

categories. See Tables 5.2, 5.3, and 5.4 for the capitation categories applicable for the different time periods.

Table 5.2 – Capitation Code Categories Effective Since January 1997

Code	Description	Age Reference
AF	ADULT FEMALES	AGE >= 20
AM	ADULT MALES	AGE >= 20
TN	TEENAGERS	AGE >=13; <=19
CH	CHILDREN	AGE >=1; <=12
NB	NEWBORNS	AGE < 1
CT	PKG C TEENS	AGE >=13; <=19
CC	PKG C CHILDREN	AGE >=1; <=12
CN	PKG C NEWBORNS	AGE < 1

Table 5.3 – Capitation Code Categories Effective in 1995 and 1996

Code	Description	Applicable Aid Categories
A	AFDC ADULT MALE - RURAL	C,F,H,S,U
B	AFDC ADULT MALE - URBAN	C,F,H,S,U
C	AFDC ADULT FEMALE – RURAL	C,F,H,S,U,M
D	AFDC ADULT FEMALE – URBAN	C,F,H,S,U,M
E	AFDC CHILD/INFANT - RURAL	C,F,H,S,U, T,1
F	AFDC CHILD/INFANT - URBAN	C,F,H,S,U,T,1
G	AFDC RELATED CHILD/INFANT – RURAL	Y, Z,2,X
H	AFDC RELATED CHILD/INFANT - URBAN	Y,Z,2,X
I	AFDC RELATED MOTHER – RURAL	E,N
J	AFDC RELATED MOTHER - URBAN	E,N

Table 5.4 – Capitation Code Categories Effective 2001

Capitation Code	Description
A1	PKG A preschool Ages 1-5

(Continued)

Table 5.4 – Capitation Code Categories Effective 2001

Capitation Code	Description
A6	PKG A Child Ages 6-12
AF	PKG A/B Adult Females
AM	PKG A Adult Males
C1	PKG C Preschool Ages 1-5
C6	PKG C Child Ages 6-12
CD	PGK C – Delivery Payment
CN	PKG C – Newborns
CT	PKG C Teens Ages 13-18
DP	PKG A/B Delivery Pymt
NB	PKG A Newborns
TN	PKG A/B Teens ages 13-20

Payment Schedule

Capitation runs the third Wednesday of every month. The BBS files, specific for each MCO/region, are available for downloading on the Thursday following the third Wednesday. The retroactive capitation process runs after the regular capitation process. This is further explained in *Section 6: PMP Disenrollment from Hoosier Healthwise*.

Distribution

Enrollment roster data files are accessible from the BBS by the MCO when they use their ECS authorization number and password. Files are also copied on tape per MCO/region as a backup.

File Layout

The layout for the MCO capitation file is on *L:\ManageCare\Managed Care Unitnit\tapespec\CapMCO2001.xls.*

Quality Control

Continual monitoring includes comparison of the Hoosier Healthwise MCO enrollment rosters (CRLD report *MGD0004B*) to RBMC PMP enroll roster listings (CRLD report *MGD0034B*), MCO capitation listings (CRLD report *MGD0002M*), and to Indiana*AIM* PMP assignment history screens.

Issue Resolution

Past issues included unpaid capitation months, half capitation versus whole capitation payment discrepancies, capitation category discrepancies, and capitation paid inappropriately such as for retroactive dates of death. The retroactive capitation process implemented in September 2000 automatically corrects most occurrences of the previously described situations.

MCO Delivery Capitation Payments

Purpose

For dates of service since January 1, 1997, MCOs are paid a fixed fee for members who deliver babies while actively enrolled in the MCO. This is in addition to the regular monthly capitation fee the MCO receives for the member. This capitation helps offset expenses involved with deliveries, as well as prenatal and postnatal care.

Payment Schedule

Delivery capitation is generated from shadow claims billed according to established billing instructions. The procedure codes in Table 5.5 trigger a delivery payment.

Table 5.5 – Codes that Generate Delivery Capitation Payments

Code	Description
59409	Vaginal Delivery Only
59410	Vaginal Delivery Including Post Partum Care
59515	Delivery of Placenta
59415	Cesarean Delivery Only
59515	Cesarean Delivery Including Post Partum Care
59612	Vaginal Delivery After Previous Cesarean
59614	Vaginal Delivery After Previous Cesarean Including Post Partum Care
59620	Cesarean Delivery Only Following Attempted Vaginal Delivery After Previous Cesarean Delivery
59622	As 59620 Including Post Partum Care

Claims are submitted as shadow claims by the MCOs. Claims must adjudicate through the EDS claims engine with a paid status to be eligible. Capitation is not generated when the codes in Table 5.5 are billed with anesthesiologist or assistant surgeon modifiers.

Distribution

Claims meeting the previously described criteria generate payment in accordance when adjudication occurs in comparison to the capitation cycle. Claims paid prior to the third Wednesday of the month generate delivery capitation on that month's cycle. Payments are included and reported to the MCOs as part of the monthly capitation cycle.

Quality Control

The SE queries for potential duplicate delivery payments corresponding to the monthly capitation cycle. The results are sent to the Managed Care Unit for an analyst to compare reported ICNs against possible duplicate delivery payments. This occurs when assistant surgeon claims are billed without the appropriate modifier. This previously occurred with anesthesiology claims, but Indiana*AIM*

now excludes anesthesiologist provider claims from generating capitation.

Issue Resolution

The Managed Care Unit analyst enters recoupment adjustments for delivery capitation generated inappropriately.

Adjustments to Capitation

Mass Adjustments

Adjustments to both monthly and delivery capitation payments are made online for an individual or capitation category, as required. Details for completion of individual and mass adjustments are in the *Teleprocessing Users Guide-Managed Care*.

The OMPP may retroactively reset capitation rates for the MCOs. The OMPP sends written notification to the Managed Care Unit. The notification includes the capitation category, time period, newly calculated rate, and the affected MCO/region. The **Capitation Rate Adj** option from the Managed Care Adjustment Menu allows the Managed Care Unit analyst to enter an adjustment amount (rate difference between new rate and original rate) per capitation category per MCO/region for each applicable month. An adjustment reason code is also required. Another Managed Care Unit analyst quality checks the entry and set up of each mass rate adjustment. Processing of the adjustments occurs during the next regular capitation cycle. Details for completion of the adjustment are in the *Teleprocessing Users Guide-Managed Care*.

Individual Member Adjustments

The MCO, Managed Care Unit analyst, or SE may identify individual member capitation adjustments. Upon identification, cross verification and notification is performed. For example, if the Managed Care Unit analyst identifies an unpaid, underpaid, or overpaid capitation record, the analyst follows up with the appropriate MCO representative for verification of their records. Conversely, a Managed Care Unit analyst verifies in Indiana*AIM* if an adjustment is indicated when identified and requested by the MCO.

Adjustments are queued by RID number from the **Recip Capitation Adj** option from the Managed Care Adjustment Menu. Processing of queued adjustments occurs during the next regular capitation cycle.

The capitation reconciliation process recognizes pending adjustments entered by an analyst when recalculating capitation. See *Capitation Payments* in *Section 6: PMP Disenrollment from Hoosier Healthwise*. Details for completion of the adjustment are in the *Teleprocessing Users Guide-Managed Care.*

Member Eligibility Adjustments

The option of adjusting capitation by changing a member's managed care PMP assignment end date is available from the **Recip Eligibility Adj** option from the Managed Care Adjustment Menu. This option has never been used and is not recommended for use in production. A systematic process recoups capitation for retroactive dates of death received by ICES. Managed Care Unit intervention is not required.

Capitation Adjustment List

The Capitation Adjustment List option from the Managed Care Adjustment Menu allows the Managed Care Unit to view adjustments in RID number order, whether mass or individual, prior to monthly capitation cycle processing. Adjustments can be viewed after nightly cycling of the window entry. Adjustments disappear from this window after being processed by the capitation cycle.

Adjustments can also be put on **hold** or **active** status in this window. Adjustments placed on hold continue to remain on this list until activated. Adjustments cannot be deleted.

Adjustment Verification

After receipt and entry of mass capitation rate adjustments, but prior to the monthly capitation cycle, both the Managed Care Unit analyst entering the adjustments and another team member review the window for correct entries. Post cycle review, either by reviewing the CRLD report *MGD0002M Capitation Payment Listing* or by reviewing sample member capitation records from Indiana*AIM* (**Recip Capitation Adj** option), is also recommended.

The same process applies to individually entered adjustments. An extra step, as described previously in *Individual Member Adjustments*, is verification between the Managed Care Unit and the MCO when either entity has identified the need for an adjustment.

Capitation Payment Reconciliation

Capitation Reconciliation CSR *IN012232* created reports for unpaid capitation for each of the MCO/regions, both active and inactive, by comparing PMP assignment history to capitation history. These reports were created subsequent to the eligibility reconciliation project, which provided files of all memberships belonging to each MCO/region. See also MCO Enrollment Roster Reconciliation.

Preliminary unpaid capitation reports were sent to the OMPP for review and approval in January 2000. Recoupment reports for retroactive dates of death since 1995 for each of the MCO/regions were also provided. The OMPP approved the reports for distribution to the MCOs in August as well as queuing of the adjustments via the August 2000 monthly capitation cycle.

The SE reran the unpaid capitation reports prior to their distribution in August, 2000. The SE also queried for potential duplicate/triplicate

delivery capitation payments. Potential duplicates were verified by reviewing delivery claims in Indiana*AIM*. Reports were developed based on the SE's queries and the Managed Care Unit's claim analysis for each applicable MCO/region. Delivery payments have been in effect for deliveries since January 1, 1997. Recoupment adjustments were entered manually.

The OMPP sent memos during the middle of August 2000 to CIGNA/Healthsource, Maxicare, and MHS, regarding forthcoming payment adjustments for unpaid capitation and recoupment adjustments for duplicate deliveries and retroactive dates of death. The OMPP then requested that EDS forward the spreadsheets to the appropriate entities. The exception, per approval by Maxicare, was providing copies of the Maxi-North and Maxi-South spreadsheets (less the pre-7/1/98 records) to MHS per their subcontractor relationship with Maxicare. SIHO was Maxicare's subcontractor for the southern region prior to July 1, 1998.

Third Party Liability Reporting

Purpose

MCO Third Party Liability (TPL) files provide member TPL information in Indiana*AIM* to MCOs. MCOs use this information in their assessments and investigations of TPL that may be in place for their Hoosier Healthwise members.

Production Schedule

The jobs that create the TPL files run the 20th of every month. Files are then available for download from the BBS on the 21st. Tapes are available the first business day after the rosters are created. EDS holds these tapes unless the MCO specifically requests distribution due to the MCO being unable to successfully retrieve the files from the BBS.

File Layout

The layout for the TPL file is located in *L:\ManageCare\Managed Care Unitnit\tape spec\TPL*.

Distribution

TPL files are accessible from the BBS when the MCOs use their ECS authorization number and password. Files are also copied onto tape per MCO/region as a backup.

IHCP Provider Enrollment Report

Purpose

Provider files list all actively enrolled IHCP providers, regardless of PMP status. MCOs use this information to pay out-of-network providers for carved-out and any other services rendered to their members out of network.

Production Schedule	This job was created by Systems, from a Medstat-type job. It runs the same time as the 11th of the month enrollment rosters.
Distribution	These files are produced on tape only. Tapes are created each month for the MCOs.
File Layout	The layout for the TPL file is located in *L:\ManageCare\Managed Care Unitnit\tape spec*\.

Interfaces with PMPs

In addition to interfaces with the MCOs, the Managed Care Unit also provides information directly to the PMPs in their networks as described in the following text.

MCO PMP Enrollment Roster

Purpose	Twice monthly enrollment rosters are sent to both RBMC and PCCM PMPs for information about members assigned to their panel.
Distribution	PMP rosters are generated on paper the 11th and 26th of every month and mailed to the PMP's **pay to** address. The roster includes any new, continuing, or terminated panel members linked to each PMP's individual or group PMP affiliation. Members are sorted alphabetically by last name under those categories. *MGD0034B* is the CRLD equivalent for the RBMC PMP enrollment roster. The roster report is in provider number order, starting with individual PMP providers then proceeding by group provider number order. PMP members of groups are in provider number order under the group number.
File Layout	The layout for the PMP Enrollment Roster file is in *L:\ManageCare\Managed Care Unitnit\tape spec*\.
Quality Control	Continual monitoring includes comparison of the Hoosier Healthwise administrative fee listings (CRLD report *MGD0003M*) to Prime*Step* PMP listings (CRLD report *MGD0005B*) and to Indiana*AIM* PMP assignment history screens.
Issue Resolution	Rosters can be reprinted from CRLD if a PMP did not receive the roster via mail.

Shadow Claims

Shadow claims are reports of individual patient encounters with an MCO's health care network. These claims, which have been reimbursed by the State to the MCO in capitation payments, contain fee-for-service equivalent detail as to procedures, diagnoses, place of service, billed amounts, and rendering or billing providers.

Purpose

The OMPP uses shadow claims to collect member-specific claim data for utilization analysis, quality control, program cost analysis, and capitation rate setting and adjustments. The claims data along with other information such as member age, sex, and county, are obtained from Indiana*AIM*, and form the foundation for OMPP analysis of managed care versus fee-for-service use patterns and development of subsequent capitation rate levels.

Submission

MCOs are provided with the *Electronic Claims Submission Manual* as well as the *Claims Resolutions Manual.* These manuals describe the specific claim submission requirements and form the basis for the technical elements required for shadow claim submission and adjudication.

Shadow claims submissions to EDS may occur at any time but must include, at a minimum, a submission of each claim type during each calendar month. Shadow claims are transmitted electronically in the ECS format as detailed in the *ECC Batch Claim Submission Manual* provided by EDS during the MCO orientation. The only exception to electronic transmission is for paper compound prescription drug claims submitted as described in the following text.

The required detail and billing instructions for each claim type is described in detail in the *IHCP Provider Manual*. In general, MCO-submitted shadow claims must adhere to the billing standards set forth in this manual for all billing providers.

Region 22

As with all other claims submitted for processing, shadow claims are assigned an ICN. The first two digits of the ICN describe region 22 for shadow (encounter) claims. Claims in region 22 adjudicate similar to fee-for-service claims until the point of payment. Since the services

reported on shadow claims have been reimbursed to the provider by the MCO, they do not generate payments.

MCO-Denied Claims

Claims submitted as shadow claims are those claims that the MCO has accepted for payment. MCO-denied claims are not submitted as shadow claims. In the event the MCO has a claim that contains both denied and paid details, the claim is submitted as a shadow claim. MCOs are also expected to submit a shadow claim to report services rendered within the network that were included in the capitation paid to a particular provider. Denied details on paid claims and services rendered under capitated arrangements are identified on shadow claims submissions as described in this section.

Denied details on HCFA-1500 claims also containing paid details are submitted as shadow claims. The denied details are identified by the use of the modifier X9 in the ECS E Record fields 16, 17, or 18. This is equivalent to field 24 on the HCFA-1500 paper claim form.

Currently, the modifier for identification of denied details on UB-92 claims is being developed.

Compound Prescription Drug Claim Submission

Compound prescription drug shadow claims must be submitted on paper on the standard claim form. Because these claims require special processing, they are sent to the Managed Care Unit director who coordinates processing with the Claims Unit. Instructions for completing the *Compound Prescription Drug Claim Form* are in the *IHCP Provider Manual*. The MCO identification number or region code, and capitation indicator must be noted in the blank space at the top of the form. The claim disposition for these paper claims is the same as electronic claims.

Elements Unique to Shadow Claims

It is the intent that shadow claims mirror fee-for-service claims, which ensures the continuity of data collected. Additional claim filing elements, unique to shadow claims processing and submission, are described in the following text.

The **MCO identification number and region identifier** is assigned to an MCO upon its enrollment in Hoosier Healthwise. This is a random number generated by Indiana*AIM* when the MCO enrollment is

entered. This is a nine-digit number with a 10-digit alphabetic character denoting the geographic region(s) of Indiana where the MCO is contracted to provide services. The MCO ID and region identifier is required on all shadow claims submissions in the fields designated in the electronic shadow claims field elements.

Value codes and value code amounts are required on UB-92 claims to designate the MCO's reimbursement methodology and actual amount paid on the claim. Omission or incorrect data in the value code fields will cause the claim to adjudicate with a denied status for one of the following reasons:

- Value code missing
- Value code amount missing
- Value code amount invalid

Value codes, specific to shadow claims, and their corresponding claim types are:

- Z1 – Inpatient DRG
- Z2 – Level of Care
- Z3 – Inpatient Per Diem
- Z4 – Outpatient
- Z5 – Nursing Home/Long Term Care Facility
- Z6 – Home Health Care
- Z7 – Other

HCFA-1500 claims that report **services rendered under a capitated arrangement** with a provider are identified by $0.01 as the billed amount.

Delivery Capitation Payments

While most shadow claims are used for data reporting and utilization purposes, claims that report maternal deliveries serve the dual purpose of data reporting and generation of a capitation payment. Delivery capitation is paid per occurrence and is generated from a paid shadow claim reporting the birth of a child to an MCO-enrolled member. Information about delivery capitation payments is in this section, under *MCO Delivery Capitation Payments*.

The *IHCP Provider Manual* gives detailed billing instructions for prenatal care, delivery, and postpartum care claims. While it is the delivery claim that generates an additional capitation payment, it is

critical for reporting, utilization, and monitoring functions that all shadow claims for maternity care are submitted.

Shadow Claims Edits and Audits

Shadow claims are subjected to appropriate system edits to ensure data validity. These edits fall into two broad categories:

- ECC precycle edits
- Claim resolution edits and audits

Precycle Edits

Precycle editing establishes the presence and validity of certain critical data elements prior to the claim's acceptance in Indiana*AIM*. For example, the RID field must contain a valid combination of numerics recognized by the system to pass the precycle edit. The precycle editing process does not attempt to link the number to a specific member's eligibility or other information. The ECC precycle edits for shadow claims are identical to those in fee-for-service ECS claims except for the addition of two edits created for shadow claims: MCO ID MISSING and MCO ID INVALID. The precycle edits are described in the *EDS Electronic Claim Capture Manual*.

Claim Resolution Edits/Audits

Claim resolution editing and auditing validates information specific to a particular enrollee's IHCP program eligibility, subprogram affiliation, and claim history. These edits and audits are designed to support benefit limits and conditions of payment set forth in state and federal program requirements and are described fully in the *Claims Resolutions Manual*. For example, a claim with a RID number that was accepted in Indiana*AIM* during precycle editing, as described above, may be denied during claim resolution editing if the member was ineligible for benefits on the date of service, or if the member name or RID on the claim did not match the name or RID on file in Indiana*AIM*.

Edits 2017 and 2018

Edits *2017* and *2018* apply only to claims a provider has billed EDS fee-for-service claims for which an MCO is responsible. The fee-for-service claim denies in Indiana*AIM* and advises the provider to bill the MCO responsible for the service. Information about these edits is in the *Claims Resolutions Manual*.

Audit Disposition

In the IHCP fee-for-service claims processing environment, generation of system edits and audits causes a claim to be suspended for review, pended to request additional information, or denied. In the shadow claims environment, claims are subjected to the same edit and audit criteria for data collection, utilization, and program comparison purposes. **Since shadow claims have been fully adjudicated by the MCO, they adjudicate in Indiana*AIM* as paid or denied.**

The fee-for-service edits and audits related to validity of the data, member eligibility, provider enrollment, or duplicate claim submissions are also active for shadow claims. Fee-for-service audits that limit the duration or frequency of specific services, restrict the place of service, or require prior authorization, are inactive for shadow claims because these matters have been resolved by the MCO during their adjudication of the claim.

The disposition of each audit applicable to shadow claims is recommended by the EDS Managed Care director or designee and approved by the OMPP Managed Care director or designee. MCOs can request a review of the disposition of a specific edit or audit with submission of the *Edit/Audit Disposition Change Request Form* to the EDS Managed Care director. A sample copy of this form is in the *Managed Care Organizations Policies and Procedures Manual*.

Generation of the fee-for-service edits and audits in the shadow claims processing environment causes claims to adjudicate with a paid or denied status in Indiana*AIM* even though payments are not actually issued. Shadow claims are not suspended or pended for review, as shadow claims are reports of claims adjudicated and paid by the MCOs to their contracted and noncontracted providers.

Duplicate/Potentially Duplicate Claims

Claims that are potential but not exact duplicates adjudicate as paid because the MCO has determined the validity of their paid claim prior to its submission as a shadow claim. MCOs can use their own criteria for medical management issues and report only fully adjudicated paid claims. Currently the potential duplicate edit is an issue when analyzing shadow claims data. A CSR has been written to modify the system to allow shadow claim adjustments, once this is complete the potential duplicate issue will be resolved.

Shadow Claims Output Documents

Indiana*AIM* acknowledges each shadow claim submitted by the MCO. This acknowledgment includes the ECS Biller Summary report and Electronic remittance advice (RA).

ECS Biller Summary

The ECS Biller Summary report shows claims accepted in Indiana*AIM* for processing in addition to claims rejected in the precycle editing process. Error code descriptions are in the *Electronic Claims Submission Manual*. This report is the basis for the application of liquidated damages that may be applied, at the discretion of the OMPP, if the acceptance rate falls below 98 percent for any single batch submission.

Remittance Advice

The electronic RA is generated for all claims accepted and adjudicated in Indiana*AIM*. Because shadow claims are adjudicated with either a paid or denied disposition, the RA for these claims indicates the disposition, and the Explanation of Benefits (EOB) error code, if applicable.

The RA is posted to the EDS ECS electronic BBS each Monday, acknowledging the claims processed during the previous week's claim cycle, and remains there for five calendar days after which time it is replaced by the next RA. MCOs should have an internal procedure for accessing the RA and distributing it among the networks as needed within this time frame. Each weekly claim cycle includes claims processed from 5 p.m. Thursday through 5 p.m. the following Thursday.

Shadow Claims Corrections

MCOs should have a procedure in place to review the biller summary reports and RA files previously described to identify claims denied in either the precycle or adjudication processes. The Biller Summary report references error codes contained in the *Electronic Claims Submission Manual*. The MCO may resubmit the corrected claim in the next batch submission.

Correction methods for the edits and audits reported on the RA that caused the claim to deny during the adjudication process can be found in the *Claims Resolution Manual*. Corrected claims should be resubmitted in the next batch submission.

HCFA-1500 and dental claims containing both paid and denied details may be completely resubmitted or denied details only resubmitted.

Resubmitted details on claims that adjudicated with a paid status deny as duplicates on the resubmission.

UB-92 claims are not adjudicated at the detail level, so denied elements must be corrected and the entire claim resubmitted.

MCOs may bring questions about any aspects of shadow claims submission and adjudication to the monthly MCO technical meeting.

Inattention to correction and resubmission of denied shadow claims may result in the assessment of liquidated damages described as follows, or as described in the MCO Broad Agency Announcement (BAA).

Quality Control

Since members can change from the Prime*Step* network to an MCO network, shadow claims update a member's detailed claim history and reflect all benefit limitations applicable to fee-for-service programs as defined in the Indiana Administrative Code. It is critical that service utilization for the Hoosier Healthwise program's risk-based enrollees is documented in Indiana*AIM* claim history for appropriate claim adjudication in the event a member should move to the Prime*Step* program or traditional Medicaid upon disenrollment from a risk-based program.

The accuracy of MCO-submitted shadow claims is essential to the integrity of the State's claim system that collects data for the IHCP's traditional programs including Hoosier Healthwise.

Shadow Claims Top Ten Error Report

The Managed Care Unit compiles and analyzes shadow claim data for each MCO/region including the 10 most frequent reasons for denials, and the number of each claim type—physician, drug, or UB-92—submitted, accepted, and rejected.

Shadow Claim Verification

In addition to the previously mentioned reports, the Managed Care Unit also verifies the adjudication of shadow claims. A sample of these claims is drawn from Indiana*AIM* and is checked for when the service was provided, when the claim was submitted and adjudicated, whether the claim was adjudicated properly, and whether the claim was appropriate for the services provided.

Liquidated Damages Report

Based on the information in the shadow claims error reports and other methods of verification, the Managed Care Unit may, at the direction of the OMPP, prepare reports for MCO liquidated damages as specified in the MCOs' contracts with the OMPP.

Terminology

Terminology specific to shadow claims is shown in Table 5.6.

Issue Resolution

MCOs generally bring unresolved shadow claim issues to the Managed Care Unit staff in the monthly MCO technical meeting.

Reference File

Updates to the reference file for region 22 shadow claim edits/audits are coordinated with the Account Services Unit as required.

Prior Authorization

MCOs are responsible for the administration of their internal PA programs. Because shadow claims are fully adjudicated by the MCOs prior to submission as shadow claims, PA activity is not tracked or recognized in Indiana*AIM* for shadow claims.

Shadow Claim Adjustment

Indiana*AIM* currently does not contain the logic required to adjust shadow claims. MCOs may correct and resubmit denied claims, but claims that adjudicate as paid may not be corrected or adjusted in Indiana*AIM*.

Table 5.6 – Shadow Claim Terminology

Term	Definition
After auditing allowed amount	The amount allowed for the claim based on the appropriate pricing methodology and the number of Medicaid allowed units. This is the fee-for-service allowance.
After auditing units	The number of units allowed after the claim has been audited against history (shadow and fee-for-service) and medical policy criteria. This is the number of Medicaid allowed units.
Before auditing allowed amount	The amount allowed for the claim based on the appropriate pricing methodology and the number of billed units
Before auditing units	The number of units allowed prior to auditing of the claim against history and medical policy criteria. This will equate to the billed number of units.
Capitation indicator	A one-byte field added to the claims record to identify services paid by the MCO on a capitated basis. This indicator is for informational purposes and has no impact on shadow claims processing.
Denied shadow claim table	A record of all shadow claims that have been denied by Indiana*AIM*. These tables do not include claims that failed precycle editing. Information on a denied claim is not subject to service limitation auditing and is not included in data used for utilization review.

(Continued)

Table 5.6 – Shadow Claim Terminology

Term	Definition
Manual pricing	The process by which an allowed amount is determined for a procedure that does not have a set rate on file. Shadow claims will not suspend for manual pricing. The *billed amount* will become the *allowed* amount.
MCO identification number	A nine-byte field used to identify the MCO submitting the shadow claim.
MCO region identifier	A one-byte field used to identify the region of the MCO submitting the shadow claim.
Paid shadow claim table	A record of all shadow claims processed and priced by Indiana*AIM*. With the exception of maternal delivery claims, paid shadow claims do not result in a financial transaction. Data from paid shadow claims is included in service limitation auditing and utilization analysis.
Post and pay	The process by which an edit is attached to a claim for informational purposes only.
Shadow claim tables	The method by which Indiana*AIM* maintains shadow claims data. This data is stored on tables separate from fee-for-service claims but does not affect the user's ability to access either FFS or encounter data.
Shadow claims	Reports of individual patient encounters with an MCO's delivery system that contain fee-for-service equivalent detail as to procedures, diagnoses, place of service, billed amounts, and rendering and billing providers. Shadow claims adjudicate in the same manner as fee-for-service claims, but do not result in a payment with the exception of claims submitted to report a maternal delivery.

Self-referral Services

Centers for Medicare and Medicaid Services (CMS) and State regulations allow members to access certain services outside the network in which they are enrolled. Capitation amounts include payment for *self-referral* services as shown below. Hoosier Healthwise members can obtain self-referral services from any IHCP-enrolled provider qualified to render the service, whether or not the provider belongs to the same network (such as Prime*Step* or an MCO network) as the member. MCOs are responsible for ensuring that the self-referral services are covered and prior authorized in accordance with *405 IAC 5*. The following are Hoosier Healthwise self-referral services:

- Services rendered for the treatment of a true emergency
- Family planning services
- Chiropractic services
- Podiatric services
- Eye care services (except eye care surgeries)
- HIV/AIDS targeted case management services
- Diabetes self-management services rendered by a chiropractor, podiatrist, optometrist , or psychiatrist outside the MCO network or to an IHCP-enrolled provider as a referral from one of these provider specialties.

Emergency Care

MCOs are responsible for providing or reimbursing for 24-hour emergency care services for Hoosier Healthwise members. This coverage must be extended to out-of-network facilities that provide emergency services to an MCO's Hoosier Healthwise enrollee. MCOs may identify diagnoses, symptoms, or conditions that qualify for emergency care reimbursement. The criteria used to define emergency conditions must be consistent with prudent layperson standards outlined in the Balanced Budget Act (BBA) of 1997 and the Emergency Medical Treatment and Labor Act (EMTALA). MCOs are not required to cover nonemergency treatment provided in emergency rooms or other facilities out of the networks. A detailed listing of diagnosis codes that qualify for emergency room reimbursement under the traditional fee-for-service program is in the *IHCP Provider Manual*. MCOs are not required to include the full range of emergency diagnoses defined by IHCP. They may define emergency conditions if prudent layperson standards are applied.

Family Planning

Members may access family planning services from any IHCP-enrolled provider qualified to render the service. Procedure and diagnosis code combinations detailed in a supplement to the *IHCP Provider Manual* define family planning services.

Chiropractic

Chiropractic services are defined as IHCP-covered services rendered by providers enrolled with a specialty 150 (chiropractor) and practicing within the scope of their license.

Podiatry

Podiatric services are defined as IHCP-covered services rendered by providers enrolled with a specialty 140 (podiatrist) and practicing within the scope of their license.

Vision Care

MCO members can seek most vision care services on a self-referral basis from IHCP providers enrolled with vision care specialties 180 (optometrist), 190 (optician), or 330 (ophthalmologist) and practicing within the scope of their license. MCOs may require that providers and facilities within their networks render vision-related surgeries, when available. The following ranges of CPT codes define vision-related surgeries:

- 65091-65114 – Removal of eye and related procedures
- 65125-65175 – Ocular implants and related procedures
- 65205-65265 – Removal of foreign body from eye (unless billed with an emergency diagnosis code)
- 65270-65290 – Repair of laceration and related procedures
- 65400-66999 – Procedures on anterior segment including cornea, anterior chamber, anterior sclera, iris, lens, and cataract removal
- 67005-67299 – Procedures on posterior segment including vitreous, retina, sclera
- 67311-37999 – Procedures on ocular adnexa including orbit, eyelids, brow, and related procedures
- 68020-68899 – Conjunctiva and related procedures

HIV/AIDS Care Coordination

HIV/AIDS Care Coordination services are billed using a single local procedure code, Z5950. One unit of service billed with this code equals 15 minutes. The MCO is expected to work with the HIV/AIDS care coordinator to avoid duplication of services with any case management services provided by the MCO. The HIV/AIDS care coordinator will focus on the nonmedical needs of the member within the scope of services provided under the 1915b-waiver program, Hoosier Healthwise. Additional information about this service *42 U.S.C. 1396n (g)*, administered by the Indiana State Department of Health, is in the *IHCP Provider Manual*.

Diabetes Self-management Training

Diabetes Self-management Training Services are available to Hoosier Healthwise members on a self-referral basis from any chiropractor, podiatrist, optometrist or psychiatrist outside the MCO network who has had specialized training in the management of diabetes. MCOs may require that diabetes self-management training services rendered by other qualified health care professionals be rendered within the MCO network or have prior approval for payment to out-of-network providers. Specific information about this benefit is provided in *Indiana Medicaid Update E98-05* and *Senate Enrolled Act (SEA) No. 184*.

Carved-out Services

The following broad categories of service, covered by IHCP but excluded from the capitation payment, are payable as fee-for-service claims in IHCP and are not included in the scope of care managed by the MCOs. These services are typically referred to as *carved-out* services or *carve outs*.

Services in the categories listed in the following text are generally excluded from the capitation payments based on the provider type and specialty of the billing provider. That is why they are referred to as carved-out services or carve outs. For example, a claim for an office visit billed by a psychiatrist with a diagnosis of depression for an MCO-enrolled member is submitted and considered for payment as a fee-for-service claim. A claim for an office visit billed by the member's PMP with a diagnosis of depression is submitted to the MCO and reimbursed according to the MCO/PMP financial arrangement. Likewise, services generally categorized above, but rendered by the PMP, acute care hospital, ambulatory surgery center (ASC), or other network specialist not enrolled in the IHCP system as one of the specialties listed above, are the responsibility of the MCO regardless of the diagnosis.

Behavioral Health

Behavioral health consists of mental health and substance abuse services rendered by providers enrolled in IHCP with a mental health specialty. Specialties include psychiatric hospital, outpatient mental health clinic, community mental health clinic, psychiatrist, psychologist, certified psychologist, health services provider in psychology, certified social worker, certified clinical social worker, and psychiatric nurse. Services related to the treatment of substance

abuse or chemical dependency are included in IHCP's mental health benefit. Mental health and substance abuse services rendered in an acute level facility remain the financial responsibility of the MCO.

Dental

Dental services rendered by providers enrolled in an IHCP dental specialty (specialties are endodontist, general dentistry practitioner, oral surgeon, orthodontist, pediatric dentist, periodontist, pedodontist, and prosthodontist).

School Corporation

These services are provided by a school corporation as part of a student's individualized education plan (IEP). They are billed by the school corporation, and must be enrolled as Type 12, Specialty 120 in the IHCP.

Services Related to Self-referral and Carved-out Services

Services related to the self-referral and carved-out services described above **remain the financial responsibility of the MCO**. Examples of related services include pharmacy, transportation, ASC, and acute care hospital expenses that may have been incurred by the member during a course of treatment. Pharmacy and ASC expenses incurred in relation to a covered dental procedure, for example, remain the financial responsibility of the MCO even though the MCO may not be liable for the primary procedure. Likewise, the MCO retains financial responsibility for pharmacy and other related expenses incurred in conjunction with outpatient mental health care treatment.

If an MCO is notified that an excluded service will be rendered, the MCO may attempt to manage the care by requesting that a provider use the MCO network facilities and other ancillary providers. If the provider uses out-of-network facilities, the MCO must reimburse the facility and ancillary providers for medically necessary services at IHCP rates.

Interfaces within EDS

Provider Enrollment

The Provider Enrollment Unit is responsible for processing the PMP enrollments submitted to EDS from the MCOs. PMP enrollments in an MCO often must be coordinated with the PMP's disenrollment from a different Hoosier Healthwise network.

Client Services

The Client Services Unit frequently receives inquiries related to members or providers in a Hoosier Healthwise MCO network. Inquiries come from phone calls, on-site visits, or workshops conducted by EDS. The Managed Care Unit is responsible for assisting this unit in matters related to Hoosier Healthwise policy or procedures to resolve issues raised to the Client Services Unit.

Systems

The Managed Care Unit works with Systems on all CSRs and other electronic and data exchange issues that affect the MCO including capitation payments, enrollment rosters, and shadow claims submission. A representative from the electronic claims group routinely attends the monthly MCO technical meeting to assist with shadow claims issues. SEs attend the meeting or participate by conference call as required for specific matters.

Section 6: PMP Disenrollment from Hoosier Healthwise

Overview

Disenrollment of a PMP from the Hoosier Healthwise program has implications for the members assigned to the PMP, the managed care entity from which the PMP disenrolls, and (if applicable) the managed care entity in which the PMP enrolls following a disenrollment. This section provides an overview of the program policy and a brief explanation of the results of various disenrollment scenarios.

This information was provided to MCOs and the enrollment broker for use by their staff members that submit PMP disenrollment requests to EDS.

Purpose

To encourage the member/PMP relationship and maintain continuity of care when a PMP disenrolls from Hoosier Healthwise or changes networks within the Hoosier Healthwise program

Disenrollment Types

PMP disenrollments fall into two general categories:

- **Disenrollment without re-enrollment**—Applies in circumstances where the PMP disenrolls, or is disenrolled, from the current Hoosier Healthwise network and is not available to members in a different Hoosier Healthwise network. Examples include the PMP's death, loss of license, retirement, relocation out of a Hoosier Healthwise service area, or disenrollment from the Hoosier Healthwise program for any other reason.
- **Disenrollment with re-enrollment—**Allows an orderly transition of Hoosier Healthwise members assigned to a PMP from one Hoosier Healthwise network or service location to the same PMP in a different Hoosier Healthwise network or service location.

Outcomes

The primary distinction between the two disenrollment types is the manner in which members assigned to the disenrolling PMP are reassigned to the same or a new PMP and how the assignment is

communicated to them. Members linked to a PMP who is disenrolled and re-enrolled are usually auto-assigned to the same PMP in a different network or service location, while members assigned to a PMP who is disenrolled without re-enrollment are usually notified to self-select a new PMP and are linked through a manual assignment process with Lifemark. ***The goal in both instances is to avoid disrupting a member's ability to access health care in the Hoosier Healthwise program.***

Disenrollment Requests

A managed care entity requests that the PMP be disenrolled from its network based on the information available at the time of the request. The disenrollment coordinator in the EDS Managed Care Unit reviews the request and may change the disenrollment type if additional information about the disenrollment becomes available or if the managed care entity request does not follow the program's intent.

Each managed care entity provides the EDS Managed Care Unit with a list of representatives who are trained and authorized to submit PMP disenrollments. The managed care entity also keeps this list updated as responsibilities change.

A managed care entity notifies the EDS PMP disenrollment coordinator of the intent to disenroll a PMP within five working days of receipt or issuance of the disenrollment request. EDS does not process the disenrollment until the disenrollment request is , but advance notification allows the opportunity to begin the coordination of enrollment in another network, if needed.

Managed care entities submit fully completed requests for disenrollment to the EDS PMP disenrollment coordinator at least five working days prior to the 24th of the month for RBMC mandatory requests.

PMP Disenrollment Processing Procedures—Internal

The PMP disenrollment coordinator reports to the EDS Managed Care director. The PMP disenrollment coordinator is responsible for the administration, oversight, and processing of the PMP disenrollment function for the Hoosier Healthwise program. The PMP disenrollment coordinator serves as the point of contact for all managed care entities that submit PMP disenrollments on behalf of any RBMC or PCCM delivery system. The PMP disenrollment coordinator ensures that each disenrollment is submitted and processed in accordance with the policies

of the Hoosier Healthwise program to maintain continuity, consistency, and accuracy in the PMP disenrollment function. Specific responsibilities include but are not limited to the following:

- Point of contact for all managed care entities regarding PMP disenrollment from Hoosier Healthwise
- Receipt of all PMP disenrollments with required documentation from persons authorized by the network as fully trained in the disenrollment process
- Verification of the disenrollment reason with the network or PMP
- Resolution of any discrepancies among the information contained in the disenrollment request, the re-enrollment request, and current information in Indiana*AIM*
- Assignment of disenrollment reason code in Indiana*AIM*
- Coordination of PMP enrollment in a different network with the EDS Provider Enrollment Unit, if required
- Coordination with Indiana*AIM* SEs as required for temporary or permanent changes to system logic
- Maintenance of the *PMP Disenrollment Tracking Log*
- Resolution, tracking, monitoring, and reporting of PMP disenrollment requests not in compliance with the Hoosier Healthwise program policy
- Confirmation of disenrollment with requestor
- Documentation of disenrollment activity on *PMP Disenrollment Checklist*
- Request for quality check by independent reviewer on each disenrollment processed
- Postproduction monitoring of member reassignments

The PMP Disenrollment process is closely tied to other critical managed care functions including auto-assignment, PMP enrollment, payment of capitation and administrative fees, and generation of enrollment rosters. Because disenrollment is one component of an integrated system, the timing of disenrollments has an impact on other Hoosier Healthwise functions. All entities involved in the PMP disenrollment process must be fully trained, must understand the outcome of requests, and must follow workflow procedures and time frames as provided.

The terminology describing the PMP disenrollment process to the requestors (Disenrollment without Re-enrollment/Disenrollment with

Re-enrollment) is different than the disenrollment processing reason codes in Indiana*AIM*. The PMP disenrollment coordinator is responsible for reviewing the request and assigning one of the following PMP disenrollment reason codes:

- PCCM Mandatory
- PCCM Voluntary
- RBMC Mandatory
- RBMC Voluntary

Tables 6.1 and 6.2 provide general guidelines for the PMP disenrollment coordinator to use for selecting a disenrollment reason code based on the request submitted. The PMP disenrollment coordinator may change the reason code as needed to accommodate any special circumstances or to comply with the stated policy. Any specific requests from MCOs that are not in compliance with the stated policy are referred to the OMPP for a determination prior to processing.

Table 6.1 – PMP Disenrollment/ PCCM

PCCM Disenrollment Request Reason	System Reason Code
PMP moves out of Indiana	PCCM Voluntary
PMP disenrolls from Hoosier Healthwise entirely for any reason	PCCM Voluntary
PMP disenrolls from Prime*Step* to enroll in an MCO network	PCCM Mandatory
PMP disenrolls from a group location to open an individual location or vice versa	PCCM Mandatory
PMP disenrolls from one group to enroll as a PMP in a different group	PCCM Mandatory
Any circumstance that causes a PMP to loose eligibility for IHCP	PCCM Mandatory

The significant difference between PCCM voluntary and mandatory reasons is the timing of the disenrollment. Members linked to PMPs disenrolled with a *PCCM voluntary reason code* are placed on the potential table for 30 days, during which time they may call the Hoosier Healthwise Helpline to select a new PMP. Members who have not had a new PMP selection entered in Indiana*AIM* at the end of 30 days are auto-assigned to a new PMP. Members linked to PMPs who were disenrolled with a *PCCM mandatory reason code* are placed on the potential table for immediate auto-assignment effective on the

next first or 15th of the month. See *Section 8: Auto-assignment* for information about the auto-assignment process.

Table 6.2 – PMP Disenrollment /RBMC

RBMC Disenrollment Request Reason	System Reason Code
PMP moves out of Indiana	RBMC Mandatory
PMP death, retirement	RBMC Mandatory RBMC Voluntary
PMP disenrolls from Hoosier Healthwise entirely for any reason	RBMC Mandatory
PMP disenrolls from an MCO network to enroll in a different MCO network or Prime*Step*	RBMC Mandatory
PMP disenrolls from a group location to open an individual location or vice versa	RBMC Mandatory
PMP disenrolls from one group to enroll as a PMP in a different group	RBMC Mandatory
Any circumstance that causes a PMP to loose eligibility for IHCP	RBMC Mandatory

The significant differences between RBMC voluntary and mandatory disenrollment reasons are the timing of the disenrollment and the manner in which the members assigned to the disenrolled PMP are reassigned to a new PMP. Members linked to a PMP disenrolled with an *RBMC voluntary reason code* are placed on the potential table indefinitely. During this time members may call the Hoosier Healthwise Helpline to select a new PMP. Members who do not have a new PMP selection entered in Indiana*AIM* remain on the potential table. The PMP disenrollment does not become effective until all of the members linked to the PMP have been reassigned. Requests for RBMC mandatory PMP disenrollments are approved in Indiana*AIM* only on the 24th of the month. Members linked to PMPs disenrolled with an *RBMC mandatory reason code* are placed on the potential table for immediate auto-assignment effective on the first of the following month. See *Section 8: Auto-assignment* for information about the auto-assignment process.

Checklist

Once the PMP disenrollment coordinator has reviewed the disenrollment request and selected a reason code, the checklist provides itemized steps needed to accurately complete the disenrollment and verify the results. A copy of the checklist is

included in this section under the subheading *Hoosier Healthwise PMP Disenrollment Forms and System-Generated Letters*.

Windows

Information about Indiana*AIM* windows and fields required for the processing of a PMP disenrollment is in the *Teleprocessing Users Guide-Managed Care*.

PMP Disenrollment Policy—Historical Perspective

Original Disenrollment Logic

- PCCM Voluntary—Allows member self-selection to a new PMP during 30-day window. Auto-assigns members who have not self-selected by the 24th day of the end of the month in which the disenrollment is effective
- PCCM Mandatory—Auto-assigns members
- RBMC Voluntary—Requires manual reassignment of all members prior to disenroll effective date
- RBMC Mandatory—Auto-assigns all members to a different PMP in the MCO, maintaining the member/MCO relationship

Updated Disenrollment Logic

The original auto-assign logic linked members to their MCO when the PMP left the MCO network. The logic was changed to maintain the member/PMP link in instances where the PMP was available in a different network within Hoosier Healthwise.

Hoosier Healthwise PMP Disenrollment Forms and System-generated Letters

PMP Disenrollment Checklist

Indiana Health Coverage Programs

PMP DISENROLLMENT CHECKLIST

PMP Name: _____ PMP ID: _____

Group Name: _____ Group ID: _____

Disenrollment Type:	PCCM Disenrollment w/o re-enrollment	☐	PCCM Disenrollment with re-enrollment	☐
	RBMC Disenrollment w/o re-enrollment	☐	RBMC Disenrollment with re-enrollment	☐
Disenrolling Network:	PrimeStep (PCCM)	☐	Managed Care Organization (RBMC)	☐
Required Documentation:	MCO Disenrollment request form	☐	PrimeStep Disenrollment Cover form	☐
	PMP Disenrollment Notification Letter	☐	Group Disenrollment Notification Letter	☐

If any of the required documentation is missing, incomplete or inappropriate contact the submitter via e-mail. Do not return documentation to submitter or PMP.

PMP Service Location Enrollment Verification in AIM

- PMP Group Service Location(s) ☐
- Group Service Location address(s) in AIM match the request form? Yes ☐ No ☐
- PMP Individual Service Location(s) ☐
- Individual Service Location address(s) in AIM match the request form? Yes ☐ No ☐
- Actual Member Panel Size: _____ Date: _____
- Panel Hold Discrepancy? Yes ☐ No ☐
- If the PMP is re-enrolling as a PMP, is the new network PMP service location enrollment active in AIM? Yes ☐ No ☐*
- If the PMP is re-enrolling as a PMP with an MCO, is the MCO provider network enrollment active in AIM? Yes ☐ No ☐*

**If no, the disenrollment cannot be approved until the reenrollment has been entered in AIM.*

Information Entered in AIM:

Reason Code: **PG** – Mandatory ☐ **PA** – Voluntary ☐ **PQ** – PCCM PMP is moving to RBMC ☐

PO – MCO PMP is moving to PCCM ☐ **PN** – MCO PMP moving to another MCO ☐

PM – MCO Dsnrl – PMP enrolls with new MCO ☐ **PP** – MCO Disnrl – PMP enrolls with PrimeStep ☐

- Suppress Member Notification Letters? Yes ☐ No ☐

Date Processed: **Processor's Initials:**

Quality Check's Initials: _____ **Date Quality Checked:** _____

PMP network service location disenrollment effective end-date: _____

Member disenrollment notification letters suppressed? **Yes** ☐ **No** ☐

Date entered on tracking log: _____

Figure 6.1 – PMP Disenrollment Checklist

Disenrollment Request Forms – MCOs and PrimeStep

The Managed Care Unit has identified the most common disenrollment scenarios and has developed forms for the managed care entities to use to streamline and simplify the disenrollment/re-enrollment process. Please note that in all cases, the PMP's notification letter must accompany the disenrollment form, and the managed care entity from which the PMP is disenrolling is responsible for submitting the appropriate form. All PMP requests will be processed within five business days from the date EDS receives the requests.

Prime*Step* Network Disenrollment Request Form without Re-Enrollment

Use this form when a Prime*Step* PMP is disenrolling and is not re-enrolling at another location in the Prime*Step* network or with an MCO network. This form must be submitted by Lifemark and accompanied by the PMP's notification letter and Lifemark's PMP disenrollment form. The effective end date will be the date the disenrollment is processed by EDS. Unless the request is for a voluntary reason, the effective date will be the last day of the month 45 days from the date approved in Indiana*AIM*.

MCO Network Disenrollment Request Form without Re-Enrollment

Use this form when an MCO PMP is disenrolling and is not re-enrolling at another location in the same MCO network, with a different MCO network, or with Prime*Step* network. This form must be submitted by the current MCO and accompanied by the PMP's notification letter. RBMC disenrollments are processed monthly. The effective end date will be the last day of the current month if EDS processes the request by the 24th of the month. If processed after the 24th, the effective date will be the last day of the following month.

MCO Network Disenrollment Request Form with Re-Enrollment

- Use this form when an MCO PMP is disenrolling and moving from one service location address to a different service location address or group number with the same MCO network. The MCO must submit the PMP's notification letter along with the disenrollment request form. If the MCO's PMP disenrollment is processed on or before the 24th of the month, his or her members' reassignment effective date will be the 1st of the following month. Also, please note that if the PMP is not enrolled at the new service location prior to disenrolling from the original service location, the PMP's members will not be auto assigned back to the previous PMP, if the PMP does not have another active PMP service location for assignments.
- Use this form when an MCO PMP is disenrolling from an MCO and re-enrolling in Prime*Step*. This form must be submitted by the PMP's current MCO along with the PMP's notification letter. The

effective end date will be the last day of the current month if EDS processes the request by the 24th of the month. If processed after the 24th, the effective date will be the last day of the next month. Also note that if the PMP is not enrolled in the new network (Prime*Step*) prior to disenrolling from the MCO, the PMP's members will be auto assigned to another PMP.

- Use this form when a PMP in one MCO is moving to a different MCO. The current MCO must submit the PMP's notification letter along with the disenrollment request. If the MCO PMP disenrollment request is processed by the 24th of the month, his or her members' reassignment effective date will be the 1st of the next month. Please note that if the PMP is not enrolled with the new MCO prior to disenrolling from the old MCO, the PMP's members will be auto assigned to another PMP in the old (previous) MCO.

Prime*Step* Network Disenrollment Request Form with Re-Enrollment

- Use this form when a Prime*Step* PMP is disenrolling from one service location to a different service location in the Prime*Step* network. Lifemark must submit the PMP's notification letter along with the disenrollment request form. Prime*Step* PMP disenrollments are processed daily, so the effective end date will be the date EDS approves the disenrollment. If the Prime*Step* disenrollment is approved between the 1st and the 11th of the month, members' effective date with the new network will be the 15th of the current month. If the disenrollment is processed between the 12th and the 25th of the current month, the members' effective date will be the 1st of the following month. Disenrollments approved after the 25th will be effective on the 15th of the following month. Also note that if the PMP is not enrolled at the new service location prior to disenrolling from the original service location, the PMP's members will be auto-assigned to another PMP.
- Use this form when a Prime*Step* PMP is disenrolling and re-enrolling with an MCO. Lifemark must submit this form along with the PMP's notification letter and Lifemark's PMP disenrollment form. Prime*Step* PMP disenrollments are processed daily, and the effective end date will be the day EDS processes the disenrollment. If the Prime*Step* PMP disenrollment is approved between the 1st and the 11th of the month, members' effective date with the new network will be the 15th of the current month. If the disenrollment is processed between the 12th and the 25th of the current month, the members' effective date will be the 1st of the following month. Disenrollments approved after the 25th will be effective on the 15th of the following month. Also note that if the PMP is not enrolled in the new network (MCO) prior to disenrolling

from Prime*Step*, the PMP's members will be auto-assigned to another PMP.

Indiana Health Coverage Programs

HOOSIER HEALTHWISE PRIMESTEP PRIMARY MEDICAL PROVIDER (PMP) DISENROLLMENT REQUEST FORM – W/O RE-ENROLLMENT

*Please complete this form to request a PCCM PMP service location disenrollment from the Hoosier Healthwise programs. All necessary attachments must accompany the disenrollment request form (*See requirements below).*

Date submitted to EDS: _____ *PrimeStep contact name:* _____

PrimeStep contact phone number: _____ *PrimeStep contact e-mail:* _____

PrimeStep Region: _____ *Date PrimeStep received request from Group/PMP:* _____

PMP Name: _____ PMP ID: _____ *(Must be 9 digits)*

I. Is the PMP disenrolling from a PCCM PMP 'individual' service location(s)? Yes ☐ No ☐

A. Billing Service Location Address #1: _____

B. Billing Service Location Address #2: _____

C. Service Location Code: A☐ B☐ C☐ D☐ E☐ F☐ G☐ H☐ I☐ J☐ K☐ L☐ M☐

(Please check if known) N☐ O☐ P☐ Q☐ R☐ S☐ T☐ U☐ V☐ W☐ X☐ Y☐ Z☐

II. Is the PMP disenrolling from a PCCM PMP 'group' service location? Yes ☐ No ☐

Group ID: _____ (Must be 9 digits)

A. Group Service Location Address #1: _____

B. Group Service Location Address #2: _____

C. Service Location Code: A☐ B☐ C☐ D☐ E☐ F☐ G☐ H☐ I☐ J☐ K☐ L☐ M☐

(Please check if known) N☐ O☐ P☐ Q☐ R☐ S☐ T☐ U☐ V☐ W☐ X☐ Y☐ Z☐

PMP Service Location Disenrollment Desired Effective End-Date: _____

PCCM PMP service location disenrollments are processed daily:

- If a mandatory reason, the effective date will be the date the PCCM PMP service location disenrollment is approved.
- If a voluntary reason, the effective date will be the last day of the month 45 days from the date the disenrollment is approved.

**Required Attachments: PrimeStep PMP Disenrollment request cover form, PMP's notification letter with a valid signature*

Figure 6.2 – Prime*Step* Network Disenrollment Request Form without Re-Enrollment

Indiana Health Coverage Programs

HOOSIER HEALTHWISE RBMC PRIMARY MEDICAL PROVIDER (PMP) DISENROLLMENT REQUEST FORM – W/O RE-ENROLLMENT

*Please complete this form to request a RBMC PMP service location disenrollment from the Hoosier Healthwise programs. All necessary attachments must accompany the disenrollment request form (*See requirements below).*

Date submitted to EDS: _____ *MCO contact name:* _____

MCO contact phone number: _____ *MCO contact e-mail:* _____

MCO Name: _____ *MCO Region:* _____

PMP Name: _____ PMP ID: _____ *(Must be 9 digits)*

I. Is the PMP disenrolling from a RBMC PMP 'individual' service location(s)? Yes ☐ No ☐

A. Billing Service Location Address #1: _____

B. Billing Service Location Address #2: _____

C. Service Location Code: A☐ B☐ C☐ D☐ E☐ F☐ G☐ H☐ I☐ J☐ K☐ L☐ M☐

(Please check if known) N☐ O☐ P☐ Q☐ R☐ S☐ T☐ U☐ V☐ W☐ X☐ Y☐ Z☐

II. Is the PMP disenrolling from a RBMC PMP 'group' service location? Yes ☐ No ☐

Group ID: _____ (Must be 9 digits)

A. Group Service Location Address #1: _____

B. Group Service Location Address #2: _____

C. Service Location Code: A☐ B☐ C☐ D☐ E☐ F☐ G☐ H☐ I☐ J☐ K☐ L☐ M☐

(Please check if known) N☐ O☐ P☐ Q☐ R☐ S☐ T☐ U☐ V☐ W☐ X☐ Y☐ Z☐

PMP Service Location Disenrollment Desired Effective End-Date: _____

RBMC disenrollments are processed on the 24th of the month; the effective end-date will be the last date of the month if the RBMC disenrollment is approved prior to the 24th.

**Required Attachments: PMP Disenrollment request cover form, PMP's notification letter with a valid signature*

Figure 6.3 – MCO Network Disenrollment Request Form without Re-Enrollment

Indiana Health Coverage Programs

HOOSIER HEALTHWISE PRIMESTEP PRIMARY MEDICAL PROVIDER (PMP) DISENROLLMENT REQUEST FORM – WITH RE-ENROLLMENT

*Please complete this form to request a PCCM PMP service location disenrollment with re-enrollment in the Hoosier Healthwise programs. All necessary attachments must accompany the disenrollment request form (*See requirements below).*

Date submitted to EDS: _____ *PrimeStep contact name:* _____

PrimeStep contact phone number: _____ *PrimeStep contact e-mail:* _____

Date PrimeStep received request from PMP/Group: _____

PMP Name: _____ PMP ID: _____ *(Must be 9 digits)*

I. Re-enrollment Network: RBMC ☐ PCCM ☐ Effective Date: _____

A. Is the PMP re-enrolling with a MCO? Yes ☐ No ☐ If yes, MCO name: _____

B. Is the PMP re-enrollment for an individual or group service location address? Individual ☐ Group ☐

C. Is the PMP re-enrolling at a new or existing service location address? New ☐ Existing ☐

D. Group Name: _____ Group ID: _____ *(Must be 9 digits)*

a. New/Existing Service Location Address #1: _____

b. New/Existing Service Location Address #2: _____

c. Service Location Code: A☐ B☐ C☐ D☐ E☐ F☐ G☐ H☐ I☐ J☐ K☐ L☐ M☐

(Please check if known) N☐ O☐ P☐ Q☐ R☐ S☐ T☐ U☐ V☐ W☐ X☐ Y☐ Z☐

Please note if the PMP is not enrolled at the new network PMP service location prior to the approval of the disenrolling PMP service location, the PMP's member panel will be auto-assigned to another PMP.

II. Is the PMP disenrolling from a PCCM PMP individual or group service location(s)? Individual ☐ Group ☐

A. Individual Service Location Address #1: _____

B. Individual Service Location Address #2: _____

C. Service Location Code: A☐ B☐ C☐ D☐ E☐ F☐ G☐ H☐ I☐ J☐ K☐ L☐ M☐

(Please check if known) N☐ O☐ P☐ Q☐ R☐ S☐ T☐ U☐ V☐ W☐ X☐ Y☐ Z☐

D. Group Service Location Address #1: _____

E. Group Service Location Address #2: _____

F. Service Location Code: A☐ B☐ C☐ D☐ E☐ F☐ G☐ H☐ I☐ J☐ K☐ L☐ M☐

(Please check if known) N☐ O☐ P☐ Q☐ R☐ S☐ T☐ U☐ V☐ W☐ X☐ Y☐ Z☐

III. PMP PCCM Service Location Disenrollment Desired Effective End-Date: _____

Note: PCCM PMP service location disenrollments with re-enrollment within the same network are processed daily; the effective end-date will be the date the PCCM PMP service location disenrollment is approved, member re-assignments will be effective on the 1st or the 15th of the month. PCCM PMP service location disenrollments with re-enrollment to a different network are processed on the 24th of the month; the effective end-date will be the last date of the current month, member re-assignments will be effective the 1st of the following month

**Required Attachments: PMP Disenrollment request cover form, PMP's notification letter with a valid signature.*

Figure 6.4 – MCO Network Disenrollment Request Form with Re-Enrollment

Indiana Health Coverage Programs

HOOSIER HEALTHWISE PRIMESTEP PRIMARY MEDICAL PROVIDER (PMP) DISENROLLMENT REQUEST FORM – WITH RE-ENROLLMENT

*Please complete this form to request a PCCM PMP service location disenrollment with re-enrollment in the Hoosier Healthwise programs. All necessary attachments must accompany the disenrollment request form (*See requirements below).*

Date submitted to EDS: _____ *PrimeStep contact name:* _____

PrimeStep contact phone number: _____ *PrimeStep contact e-mail:* _____

Date PrimeStep received request from PMP/Group: _____

PMP Name: _____ PMP ID: _____ *(Must be 9 digits)*

I. Re-enrollment Network: RBMC ☐ PCCM ☐ Effective Date: _____

A. Is the PMP re-enrolling with a MCO? Yes ☐ No ☐ If yes, MCO name: _____

B. Is the PMP re-enrollment for an individual or group service location address? Individual ☐ Group ☐

C. Is the PMP re-enrolling at a new or existing service location address? New ☐ Existing ☐

D. Group Name: _____ Group ID: _____ *(Must be 9 digits)*

a. New/Existing Service Location Address #1: _____

b. New/Existing Service Location Address #2: _____

c. Service Location Code: A☐ B☐ C☐ D☐ E☐ F☐ G☐ H☐ I☐ J☐ K☐ L☐ M☐

(Please check if known) N☐ O☐ P☐ Q☐ R☐ S☐ T☐ U☐ V☐ W☐ X☐ Y☐ Z☐

Please note if the PMP is not enrolled at the new network PMP service location prior to the approval of the disenrolling PMP service location, the PMP's member panel will be auto-assigned to another PMP.

II. Is the PMP disenrolling from a PCCM PMP individual or group service location(s)? Individual ☐ Group ☐

A. Individual Service Location Address #1: _____

B. Individual Service Location Address #2: _____

C. Service Location Code: A☐ B☐ C☐ D☐ E☐ F☐ G☐ H☐ I☐ J☐ K☐ L☐ M☐

(Please check if known) N☐ O☐ P☐ Q☐ R☐ S☐ T☐ U☐ V☐ W☐ X☐ Y☐ Z☐

D. Group Service Location Address #1: _____

E. Group Service Location Address #2: _____

F. Service Location Code: A☐ B☐ C☐ D☐ E☐ F☐ G☐ H☐ I☐ J☐ K☐ L☐ M☐

(Please check if known) N☐ O☐ P☐ Q☐ R☐ S☐ T☐ U☐ V☐ W☐ X☐ Y☐ Z☐

III. PMP PCCM Service Location Disenrollment Desired Effective End-Date: _____

Note: PCCM PMP service location disenrollments with re-enrollment within the same network are processed daily; the effective end-date will be the date the PCCM PMP service location disenrollment is approved, member re-assignments will be effective on the 1st or the 15th of the month. PCCM PMP service location disenrollments with re-enrollment to a different network are processed on the 24th of the month; the effective end-date will be the last date of the current month, member re-assignments will be effective the 1st of the following month

**Required Attachments: PMP Disenrollment request cover form, PMP's notification letter with a valid signature.*

Figure 6.5 – Prime*Step* Network Disenrollment Request Form with Re-Enrollment

Letters to Disenrolling PCCM PMPs

Date

PMP Contact Name
PMP Address
PMP Address
PMP Address (or blank if not needed)

Dear PMP:

Effective MM/DD/YY, you will no longer be participating in the Prime*Step* (Primary Care Case Management) network of Hoosier Healthwise. You are being disenrolled from Prime*Step* per your request.

You are responsible for members assigned to you under the Prime*Step* program until MM/DD/YY.

If you have any questions regarding your disenrollment, please contact the Hoosier Healthwise Helpline at 1-800-889-9949.

Sincerely,

The Hoosier Healthwise Program

Figure 6.6 – Disenrollment Letter to Prime*Step*/PCCM PMP

Date

PMP Contact Name
PMP Address
PMP Address
PMP Address (or blank if not needed)

Dear PMP:

Effective MM/DD/YY, you will no longer be participating in the Prime*Step* (Primary Care Case Management) network of Hoosier Healthwise. You are being disenrolled from the program due to Disenrollment Reason.

You are responsible for members assigned to you under the Prime*Step* program until MM/DD/YY.

If you have any questions regarding your disenrollment, please contact the Hoosier Healthwise Helpline at 1-800-889-9949.

Sincerely,

The Hoosier Healthwise Program

Figure 6.7 – Disenrollment Letter to Prime*Step*/PCCM PMP

Letter to Member of Disenrolled PrimeStep/PCCM PMP

Date

Member's First and Last Name
Member's Address Line 1
Member's Address Line 2
Member's City, State, Zip Code

Dear Hoosier Healthwise Member:

Effective MM/DD/YYYY your current Hoosier Healthwise doctor will no longer be participating as a Primary Medical Provider (PMP) in Hoosier Healthwise. This is to let you know that you must select another Hoosier Healthwise doctor or one will be chosen for you.

You must call the Hoosier Healthwise Helpline at 1-800-889-9949 to select your new doctor.

Sincerely,

The Hoosier Healthwise Program

Figure 6.8 – Letter to Member/PCCM PMP Disenrolled

Letter to Member Confirming New PMP/MCO and PCCM

Date

Member's First and Last Name
Member's Address Line 1
Member's Address Line 2
Member's City, State, Zip Code

Dear Hoosier Healthwise Member:

Effective _____ your current Hoosier Healthwise doctor will no longer be participating in the Hoosier Healthwise program. This is to let you know that starting _____, your new Hoosier Healthwise personal doctor will be

PMP Name
PMP Address
PMP Phone

This is the doctor you will go to for your medical care. Because you are a Hoosier Healthwise member, your personal doctor is available 24 hours a day, 7 days a week. Most important to you, your personal doctor can give you medical care for your individual health care needs. Your personal doctor will treat you, and arrange for visits to specialists and hospital care when you need it.

As a Hoosier Healthwise member, you should see your personal doctor before you go anywhere else for medical care. You do not need to go to the emergency room unless it is a true emergency; if you are unsure, call your Hoosier Healthwise doctor for advice.

If you have any questions about Hoosier Healthwise, either call your personal doctor at the phone number listed above or call <phone of new PMP's delivery system>.

Sincerely,

The Hoosier Healthwise Program

Figure 6.9 – PMP Confirmation Letter to Members of a Disenrolled PMP in MCO or Prime*Step*/PCCM Network

PMP Disenrollment/MCO Member Letter

Date

Member's First and Last Name
Member's Address Line 1
Member's Address Line 2
Member's City, State, Zip code

Dear Hoosier Healthwise Member:

Effective MM/DD/YY, your current Hoosier Healthwise doctor will no longer be participating in the Hoosier Healthwise program. This is to let you know must select another Hoosier Healthwise personal doctor or one will be chosen for you.

You must call the Member Services number at 1-xxx-xxx-xxxx to select your new doctor in your network (MCO Name).

Sincerely,

The Hoosier Healthwise Program

Figure 6.10 – Letter to the MCO Member Confirming Effective Date of Member's PMP Disenrollment from the MCO Network

Note: This letter to the MCO member confirms the effective date of the member's PMP disenrollment from the MCO network. If the disenrollment is initiated by the MCO, the MCO may request the letter to their member be suppressed if the PMP is available to see Hoosier Healthwise members in another network. If the disenrollment is due to the PMP's death, loss of licensure, or other reason that prevents continuation in the program, the letter to the member is not suppressed.

Letters to PMP/MCO PMP Disenrollment

Date

PMP Contact Name
PMP Address Line 1
PMP Address Line 2
PMP Address (or blank if not needed)

Dear PMP:

Effective MM/DD/YY, you will no longer be participating in the following network of the Hoosier Healthwise Program: MCO Name.

You are being disenrolled from the program due to Disenrollment Reason.

You are responsible for recipients assigned to you under the Risk Based Managed Care program until MM/DD/YY.

If you have any questions regarding your disenrollment from Hoosier Healthwise, please contact:

MCO Name
1-xxx-xxx-xxxx.

Sincerely,

The Hoosier Healthwise Program

Figure 6.11 – Letter to PMP Confirming Effective Date of a PMP Disenrollment From the MCO Network

Date

PMP Contact Name
PMP Address
PMP Address
PMP Address (or blank if not needed)

Dear PMP:

Effective MM/DD/YY, you will no longer be participating in the following network of the Hoosier Healthwise Program: MCO Name.

You are being disenrolled from the program per your request. You are responsible for members assigned to you under the Risk Base Managed Care Program until MM/DD/YY.

If you have any questions regarding your disenrollment from Hoosier Healthwise, please contact:

MCO Name
1-xxx-xxx-xxxx

Sincerely,

The Hoosier Healthwise Program

Figure 6.12 – Letter to the PMP Confirming Effective Date of a PMP Disenrollment From the MCO Network as Requested by the MCO

Date

MCO Contact Name
MCO Name
MCO Address Line 1
MCO Address Line 2
MCO City, MCO State, MCO Zip

Dear MCO Contact Name:

The following Primary Medical Provider will no longer be in your network in Hoosier Healthwise:

Effective Date:	MM/DD/YY
PMP Name:	Name of PMP being disenrolled
Disenrollment Reason:	Disenrollment Reason

If you have any questions regarding the disenrollment of this PMP please contact the Managed Care Unit at EDS.

Sincerely,

The Hoosier Healthwise Program

Figure 6.13 – Letter to the MCO Confirming Effective Date of PMP Disenrollment From the MCO Network and Reason for Disenrollment

Date

MCO Contact Name
MCO Name
MCO Address Line 1
MCO Address Line 2
MCO City, MCO State, MCO Zip

Dear MCO Contact Name:

The following Primary Medical Provider will no longer be in your network in Hoosier Healthwise:

Effective Date:	MM/DD/YY
PMP Name:	Name of PMP being disenrolled
Disenrollment Reason:	Disenrollment Reason

If you have any questions regarding the disenrollment of this PMP please contact the Managed Care Unit at EDS.

Sincerely,

The Hoosier Healthwise Program

Figure 6.14 – Letter to the MCO Confirming Effective Date of a PMP Disenrollment From the MCO Network as Requested by the MCO

Section 7: Hoosier Healthwise Children's Health Insurance Program Operations

Program Overview

The State's CHIP was established by the *Balanced Budget Act of 1997* as *Title XXI of the Social Security Act*. It allowed states to expand children's health insurance coverage to children whose family incomes exceed the requirements for Medicaid, but are insufficient to afford private health insurance coverage. The new program makes approximately $4 billion a year in federal grants available to states to provide health coverage to children younger than 19 years old with family incomes at or below 200 percent of the FPL.

Beginning July 1, 1998, Indiana implemented the first phase of CHIP as an expansion of Medicaid eligibility that resulted in an expansion of Hoosier Healthwise, the IHCP managed care program. The first phase of the Hoosier Healthwise expansion provided health coverage to children under 19 years old (born before 10/1/83) with family incomes of no more than 150 percent of the FPL. Hoosier Healthwise members who became eligible for the program in the first phase of the CHIP expansion are subject to the same benefits, program policies, and network enrollment options as the traditional Hoosier Healthwise managed care population.

> *Note: For purposes of this manual, there is no distinction made for this group of enrollees.*

Beginning January 1, 2000, Indiana implemented the second phase of CHIP for children in families whose incomes are up to 200 percent of the FPL. Members of this group are covered in the Hoosier Healthwise Managed Care Program with the Package C plan of benefits.

> *Note: For purposes of this manual, distinctions are made here for Package C benefits and policies to indicate variations from the other Hoosier Healthwise managed care packages.*

Member Eligibility for Phase II CHIP Enrollees

Eligibility criteria for this phase of the expansion include the following:

- The child must be younger than 19 years old
- The child's family income must be between 150 and 200 percent of the FPL
- The child must not have credible health insurance at any time during the three month period prior to application for the Hoosier Healthwise program
- The child's family must satisfy all cost-sharing options
- Children born to Package C enrollees are not automatically covered on their date of birth as are newborns to Hoosier Healthwise enrollees in other managed care packages. Newborns who qualify for Package C enrollment have coverage effective in the month of application.

Package C members are eligible for coverage beginning in the month of their application for Hoosier Healthwise. Members do not have up to three months of retroactive eligibility in Package C, however, Package C members who become eligible for another Hoosier Healthwise package may have retroactive eligibility in that package and not Package C.

Enrollment for Phase II CHIP Enrollees

The application process for Package C members is the same as for members in other Hoosier Healthwise packages. Once eligibility is determined, however, enrollment is conditional upon payment of a premium. Only after the premium is paid is actual eligibility transferred to Indiana*AIM*. Premium payments are made monthly, quarterly, or annually. Enrollment continues as long as the premium payments are received and the child continues to meet the other eligibility requirements. Enrollment is terminated for nonpayment of premiums after a 90-day grace period.

Enrollment in Hoosier Healthwise Package C is contingent on payment of premiums. Once enrolled, members are **required** to join a managed care plan. Hoosier Healthwise managed care network options are the same as for other Hoosier Healthwise enrollees. Members may select a PMP in an MCO or the Prime*Step* network. Members who do not select a PMP within the first 30 days of

eligibility are assigned to a PMP subject to the auto-assignment logic for Hoosier Healthwise managed care members.

Retroactive Eligibility

Only newborns born to MCO-enrolled mothers have retroactive enrollment in managed care. Package C members are eligible for enrollment in a managed care plan once premiums have cleared the bank. Members have fee-for-service eligibility retroactive to the first day of the month of application and the eligibility determination date. Enrollment in a Hoosier Healthwise managed care plan begins on the first or 15th of the month after the member self-selects or is auto-assigned to a PMP.

Provider Eligibility

MCOs and providers enrolled in the IHCP who render services to enrollees in other Hoosier Healthwise packages must also render services to enrollees in Package C.

Benefit Packages

The benefits available in Package C are the same as in Package A with the exceptions noted under the subheading *Limitations and Exclusions*.

Limitations

The following services have benefit coverage limitations in Package C that differ from those in other Hoosier Healthwise benefit packages:

- Early intervention services
- Podiatry services
- Chiropractic services
- Medical supplies and equipment
- Therapies – physical, speech, occupational, and respiratory
- Prescription drugs
- Inpatient rehabilitative services
- Mental health and substance abuse services

Exclusions

The following services, that are covered benefits for members in Hoosier Healthwise Package A, are not covered for members enrolled in Package C:

- Nursing facility services
- Private duty nursing
- Community mental health rehabilitation
- Intermediate care facilities for the mentally retarded
- Case management for persons with HIV
- Case management for pregnant women
- Case management for the mentally ill or emotionally disturbed
- Non ambulance transportation
- Christian Science nurses
- Christian Science sanatoriums
- Organ transplants
- Over-the-counter medications, except insulin
- Bed reservations in psychiatric hospitals

Enrollment Rosters

Package C members are differentiated on the MCO enrollment rosters by their Package C specific aid and capitation categories. Package C MCO members became effective with the program no sooner than April 15, 2000. The enrollment rosters, however, do not differentiate end-dates and start-dates for members changing packages without a break in their PMP assignments. For example, a previously enrolled (start date May 1, 2000) and active MCO member determined as Package C for the month of June shows the Package C capitation and aid category designations on their MCO enrollment record as soon as June, but the PMP assignment start date is reported as May 1, 2000. Package C identifiers include the following:

- CDE-AID-CATEGORY: 10
- CDE-CAP-CATEGORY: C1 (Package C Preschool Ages 1 - 5); C6 (Package C Child Ages 6-12); CD (Package C Delivery Payment); CN (Package C Newborns); or CT (Package C Teenagers).

The CRLD report comparable to the MCO's enrollment rosters, *MGD0004B*, groups members alphabetically by last name for each of the following categories for each MCO/region: new, continuing, terminated, and deleted. The summary worksheets for each MCO/region specify the number of members per capitation category, including Package C categories, in columns for continuing, new, terminated, deleted, and total current enrollees.

Capitation Payments

Package C members are differentiated on the MCO payment files by their Package C capitation categories.

The Package C capitation categories are C1 (Package C Preschool Ages 1 – 5); C6 (Package C Child Ages 6 – 12); CD (Package C Delivery Payment); CN (Package C Newborns); and CT (Package C Teens Ages 13 - 18).

The CRLD report comparable to the MCO's capitation records, *MGD0002M*, sorts members alphabetically by last name by capitation category under Current Enrollee Payments and Adjustment/Recoupment Payments sections for each MCO/region. The summary worksheets include payment subtotals for Package C capitation categories.

A later phase of Package C implementation, *Capitation Reconciliation for Retroactive Eligibility*, was promoted to production in September 2000. This process accommodates retroactive eligibility changes in lieu of members being redetermined to belong to a different benefit package than when originally assigned in managed care.

See flowchart *Retro Capitation – Auto Adjustment Process for Retroactively Replaced Eligibility* in *I:quality CI\flowchart\mancare\RetroCapProcess.xls* for more information about retroactive compensation.

Administrative Fee Payments

The Hoosier Healthwise administrative fee listing for PCCM PMPs includes Package C members assigned to the PMP receiving the report but does not differentiate between member benefit packages.

CRLD report *MGD0003M* Hoosier Healthwise administrative fee listing sorts members alphabetically by last name regardless of the benefit package.

Section 8: Auto-assignment and Member Enrollment and Disenrollment

Auto-assignment

Policy

The auto-assignment logic in Indiana*AIM* supports the policy developed by the Hoosier Healthwise program whose goal is to increase access to medical care by linking each member to a PMP. The auto-assignment process is used in the following circumstances:

- Members new to Hoosier Healthwise who have not made a PMP selection within the first 30 days of eligibility
- Members whose eligibility has been redetermined
- Members whose PMP has disenrolled from a Hoosier Healthwise network (see to *Section 6: PMP Disenrollment from Hoosier Healthwise* for detailed information)

While this is not the ideal method for linking a member to a health care provider, auto-assignment is designed to consider several factors in linking a member to an appropriate PMP. Figures 8.1, 8.2 and 8.3 provide a high level description of the logic hierarchy used in the auto-assignment process.

Timing

The auto-assignment process runs daily to link eligible members to a PMP. Initial PMP assignments made each month from the 11th through the 25th are effective on the first day of the following month. Assignments made each month from the 26th through the 10th of the following month are effective on the 15th day of the month.

PMP changes for enrolled members are processed by the enrollment broker who enters the change request directly in Indiana*AIM*. PMP changes are effective only on the first day of a month and are subject to the timing described above for initial enrollments.

Flowcharts

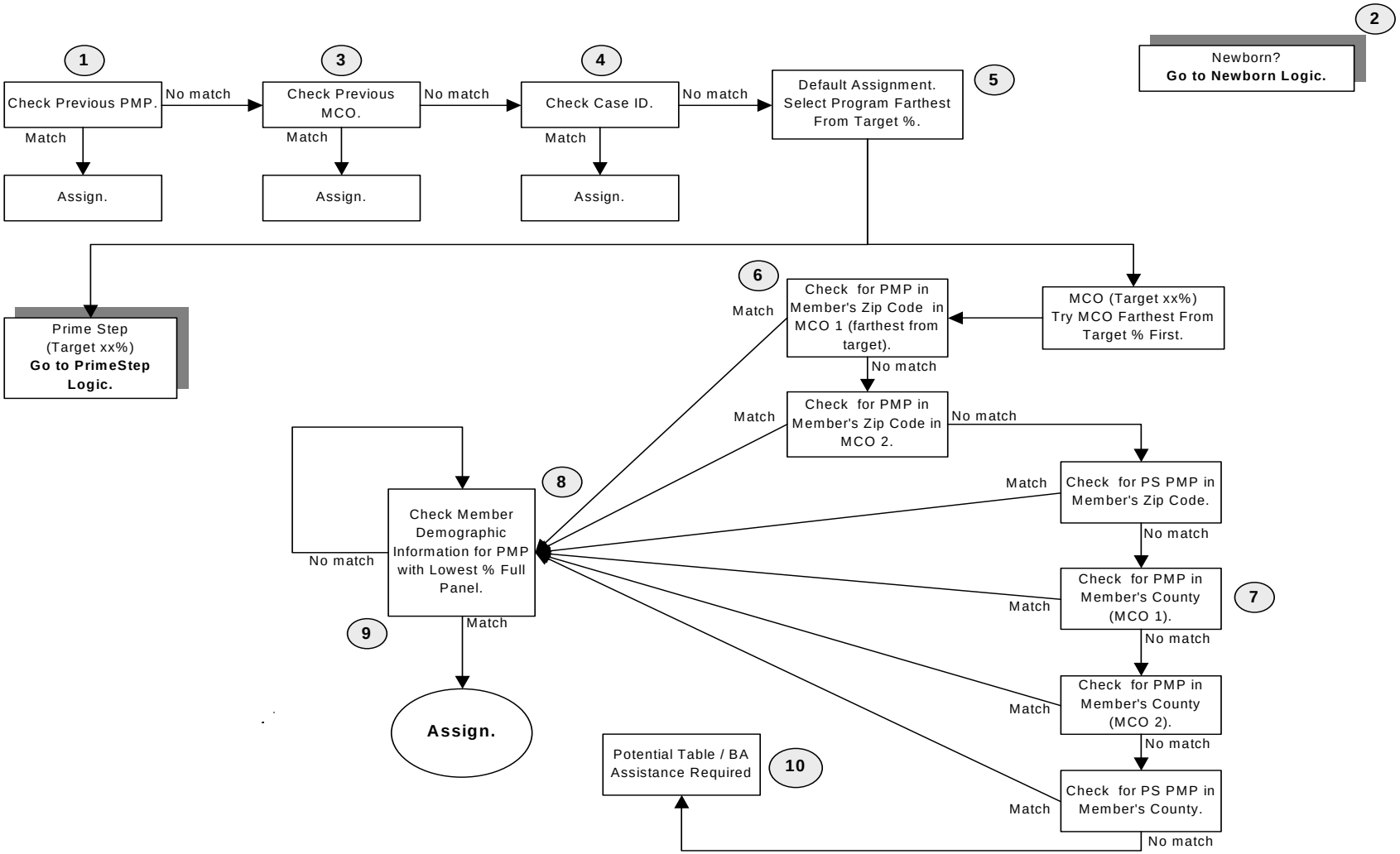


Figure 8.1 – Auto-assignment Flowchart (MCO Target)

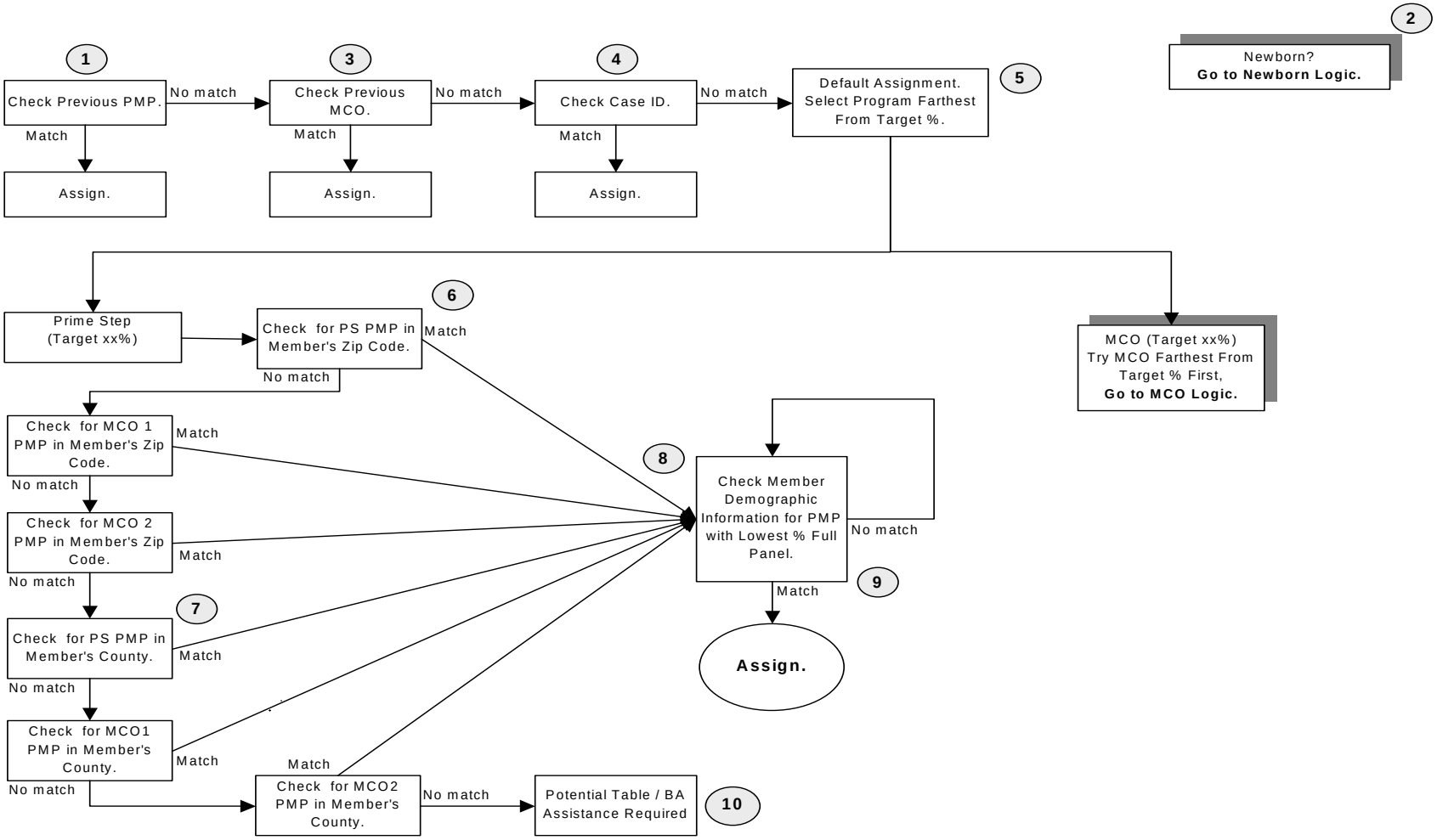


Figure 8.2 – Auto-assignment Flowchart (Prime*Step* Target)

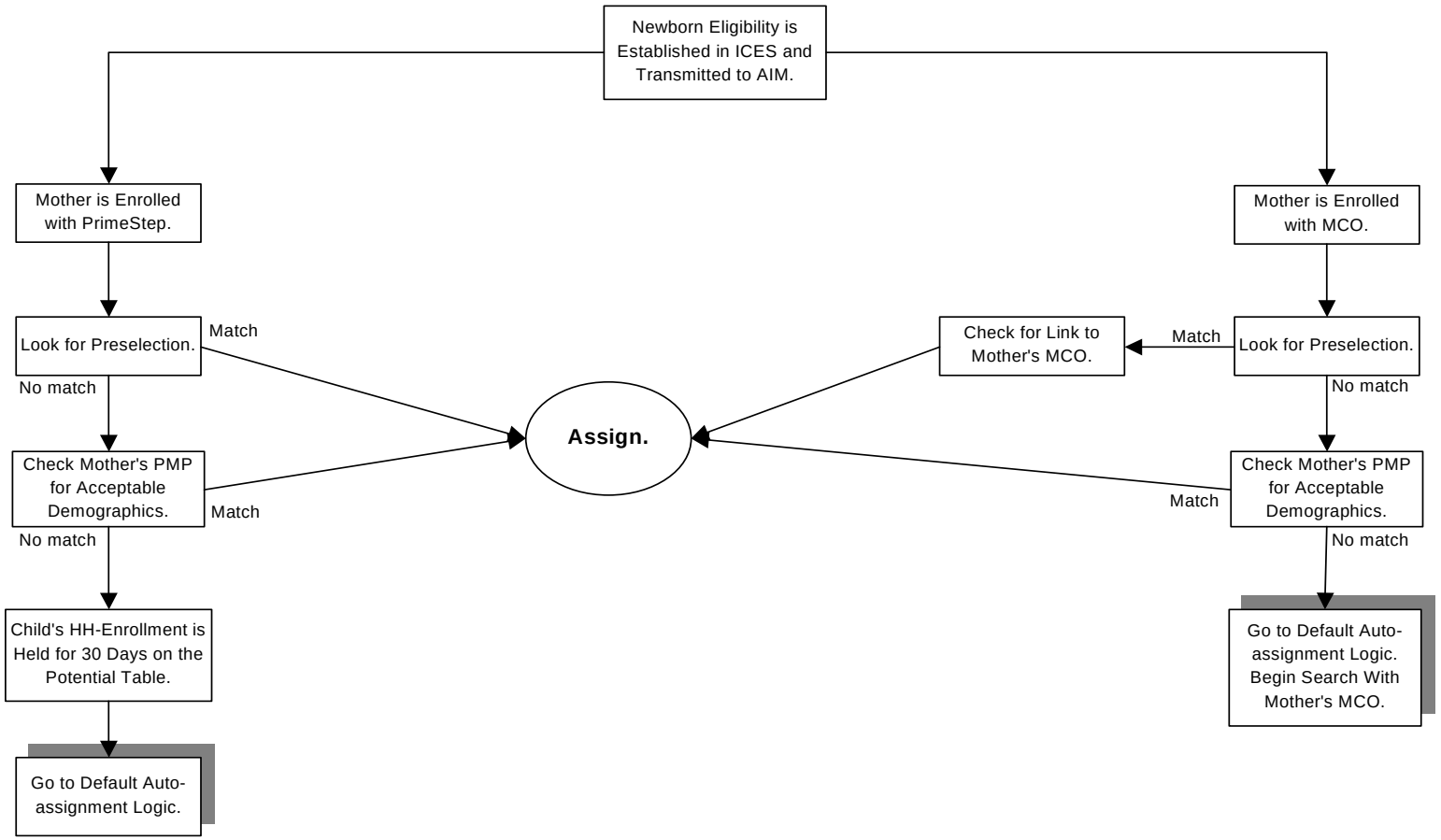


Figure 8.3 – Auto-assignment Flowchart (Newborn)

System Logic

1. *Previous PMP* - A Hoosier Healthwise member, previously assigned to a PMP who is currently enrolled as a member in the Hoosier Healthwise program, is reassigned to that PMP if appropriate within the scope of the PMP's practice and restrictions. Because continuity of care is one of the cornerstones of the Hoosier Healthwise program, the reassignment of a member to the previous PMP takes precedence over other auto-assignment logic in Indiana*AIM*. This logic supercedes the PMP panel size limits, and allows auto-assignment to the full panel of a previous PMP. Assignment to the member's previous PMP is the only instance in which geographical boundaries are not considered. Assignments to the previous PMP are made without regard to county and region boundaries. *If there are two active PMP service locations, the assignment is made to the service location with the oldest effective start date*.
   - A member who lost Hoosier Healthwise eligibility and is re-entering the program after a gap in coverage is auto-assigned to the previous PMP if the assignment is still appropriate within the PMP's scope of practice (for example, the member has not reached an age outside the scope of practice during the gap in coverage). After a lapse in coverage, a member is linked to the prior PMP in the PMP's currently open network. A member who was previously assigned to the PMP in the Prime*Step* network would be assigned to the same PMP in an MCO if that is the PMP's currently open network.
   - If the assignment remains appropriate for the PMP's scope of practice, a member who is auto-assigned to the previous PMP at the time of re-determination (with no lapse in coverage) remains in the same network, unless the PMP has disenrolled from the network. For example, if the PMP's open program is in an MCO at the time member eligibility is re-determined, but the PMP was in Prime*Step* at the time of the member's last assignment, the member is assigned to the same PMP and remains in Prime*Step*.
   - The auto-assignment previous PMP logic does not consider a member and physician relationships that may have existed outside of the member and PMP assignment in the Hoosier Healthwise Managed Care Program.
   - If a PMP disenrolls from a network or service location and has an active service location in the same or different system, the members who were linked to the PMP are auto-assigned to the same PMP in the new network or service location if the

assignment is appropriate for the PMP's scope of practice criteria at the new service location.

2. *Newborns* - Newborns whose MCO-enrolled mothers have made a pre-birth PMP selection to a PMP in their MCO are assigned to the pre-selected PMP at the time eligibility is established in Indiana*AIM* with the initial ICES transmission. This PMP assignment is retroactive to the date of birth. Newborns whose MCO-enrolled mothers have not preselected a PMP are auto-assigned to a PMP in the network of the mother's MCO. The enrollment broker does not allow an MCO-enrolled mother to select a PMP outside the MCO network for a newborn preselection. An MCO-enrolled mother can request a PMP change after the birth of her child. This assignment will have a future effective date. This PMP assignment is also retroactive to the date of birth. Assignments are based at the MCO level; however, assignment to a specific subsystem within the MCO is not considered. The mother has the option to choose a different PMP for the newborn either within or outside the MCO within 30 days of giving birth. The MCO retains responsibility from the date of birth until the effective date of the PMP change out of the network.

3. *Previous MCO* - If there is not a previous PMP relationship, the auto-assignment logic looks for a previous relationship with a currently enrolled MCO and attempts to assign the member to an appropriate PMP in the network in which the member may have a previously established case management history and familiarity with the network. If an appropriate PMP is not found in the previous MCO in the member's ZIP code or county, the process moves to case ID logic, and then to default logic.

4. *Family Relationships* - For members other than newborns, if there is no previous MCO relationship on file, the system searches for a PMP based on the relationship of other family members, searching for a case identification match first, and then for appropriateness within the scope of practice restrictions. The DFC caseworker assigns a case identification number to all family members living in the same household at the time of determination or redetermination. Family members who do not live in the same household or who have different guardians may have different case identification numbers.

5. *Default* - In the absence of a previous PMP, MCO, or case identification relationship, auto-assignment logic attempts to make an appropriate PMP assignment. The default level of the auto-assign logic attempts to establish and maintain equal memberships between the Prime*Step* and the MCO networks within a region. For

example, in a region in which Prime*Step* had an established network before an MCO contract, the Hoosier Healthwise members in the region were assigned to PMPs within the Prime*Step* network. After an MCO network is established in that region, the auto-assignment logic attempts to assign members to the new MCO network until the membership is equal.

6. After the default auto-assignment logic has identified the delivery system (Prime*Step* or MCO) and the network (MCO) farthest away from its target percentage, the default logic attempts to find an appropriate PMP within that network in the same ZIP code as the member's residence. If an appropriate PMP is not located within the member's ZIP code in the targeted MCO, the logic moves to the PMPs within the member's ZIP code in the MCO second furthest from their target percentage, and then to PMPs in the member's ZIP code in Prime*Step*.
7. When an appropriate PMP match is not made in any available network in the member's ZIP code, the process returns to the originally targeted delivery system and attempts to find an appropriate PMP in the same county as the member's residence. The exception to the county logic is in Marion County, where the logic first looks for an appropriate PMP in the same county quadrant as the member's residence before proceeding to the county level. The process continues to look for an appropriate PMP at the county level in each available network.
8. At any point during steps six and seven where there are available PMPs, auto-assignment attempts assignment to the PMP with the lowest percentage of filled panel size. For example, in Step 7., if the targeted plan has two PMPs in the member's ZIP code – PMP 1 enrolled with a desired panel size of 2,000 members with 200 assigned members, and PMP 2 enrolled with a desired panel size of 200 with 100 assigned members – auto-assignment attempts to make the assignment to PMP 1 because that PMP is 90 percent away from the desired panel size while PMP 2 is 50 percent away from the desired panel size.
9. After the auto-assignment process has targeted the PMP farthest away from the desired panel size, the logic determines whether the assignment is appropriate based on the demographic characteristics of the member and the PMP contained in Indiana*AIM*. If the assignment to PMP 1 (described previously) is inappropriate based on the age or gender of the member or the PMP's scope of practice restrictions, the process returns to Step 8 to find the PMP the next farthest from the desired panel size.

10. When the auto-assignment logic has searched all networks available in the member's county and has not found an appropriate PMP match, the member's name appears on a *BA Assistance Required* report to the enrollment broker. Members who cannot be matched to an appropriate PMP in the auto-assignment process must be manually assigned to an appropriate PMP. Members who are not manually assigned to a PMP remain enrolled in Traditional Medicaid (fee-for-service), are carried on the potential assignment table in *IndianaAIM*, and are auto-assigned when an appropriate PMP becomes available in any network.

Special Characteristics of Auto-assignment

Rules for determination of auto-assignment start date are as follows: If the day that the auto-assignment is processed falls between the 1st and the 10th of the month then the PMP assignment start date will be the 15th of the current month. If the day that auto-assignment is processed falls between the 11th and the 25th then the PMP assignment start date will be the 1st of the next month. If the day that the auto-assignment is processed falls on or between the 26th and the end of the month then the PMP assignment start date will be the 15th of next month.

Auto-assignment nuances are listed below:

1. Previous PMP
   - Assignment is made to the PMP's oldest service location if the member can be assigned to it.
   - Assignment will be made to the next oldest service location if the member could not be assigned because of the PMP's scope of practice.
   - Panel size is not looked at.
   - Panel hold is not looked at.
   - Aid category to provider specialty edit is not performed here.
   - A female member previously linked to an OB-GYN will be re-linked to the same OB-GYN if the all-women-indicator is on and she is not in a Pregnancy aid category.
   - As noted above, a member must remain within the PMP's scope of practice.
2. Previous MCO
   - Assignment is made to the PMP's oldest enrolled service location
   - All date logic is looking at current date instead of auto-assignment start date.
   - Panel size limit must be greater than actual panel size in order for a provider to be considered.

- Panel hold indicator must not be active in order for a provider to be considered.

3. Newborns
   - If the mother is in Prime*Step*, then preselection must be in same region.
   - If the mother is in an MCO, then preselection must be in the same MCO and region.
   - If the mother does not have an assignment, then the preselection is allowed.
   - PCCM newborns will be assigned back to their mother's PMP if possible starting on auto-assignment start date.
   - RBMC Newborns will be assigned back to the DOB only in the instance where the mother was in an MCO at the time of the newborn's birth.
   - The newborn will be assigned to the MCO that the mother was in at the time of birth.
4. Case Logic
   - Uses same program to check PMPs as Previous PMP logic so rules are the same.
5. Default
   - Delivery systems that will be targeted for auto-assignment are looked at in target percent order.
   - Service locations are looked at by oldest enrolled service location.
   - Panel size limit must be greater than actual panel size in order for a provider to be considered.
   - A panel hold must not be active in order for a provider to be considered.
   - Aid category to provider specialty editing is done here.
6. Members who are in designated Wards and or Fosters aid category are not auto assigned. Instead, they are in a voluntary managed care designation. These members may choose PMPs but are not auto assigned to PMPs. When a PMP disenrolls (this includes service location changes) these members must request relinkage or assignment to their PMP if the PMP disenrolls or re-enrolls.

IndianaAIM Auto-assignment Start/Stop Reason Codes

Table 8.1 identifies the Indiana*AIM* auto-assignment start/stop reason codes. Codes designated with **B** are both start and stop codes; codes designated with **N** are start codes; codes designated with **Y** are stop codes.

Table 8.1 – Indiana*AIM* Auto-assignment Start/Stop Reason Codes

Number	Description	Code
01	Approved Change	B
02	New Eligible	N
03	6 Month PMP change	B
04	Newborn auto-assign change	B
05	Recipient-initiated MCO disenrollment	B
06	Redetermination	B
07	Death	Y
08	Disenroll from HH	Y
09	Expired Managed Care Segment	Y
10	PCCM Voluntary Disenroll	B
11	RBMC Voluntary Disenroll	B
12	PCCM Mandatory Disenroll	B
13	RBMC Mandatory Disenroll	B
20	Auto assigned–Newborn	B
21	Auto Assigned-Case Assignment	B
22	Auto Assigned-Previous PMP	B
23	Auto Assigned–Default	B
24	Auto Assigned-PCCM Disenrolled	B
25	Auto Assigned-RBMC Disenrolled	B
26	Auto Assigned-Newborn Preselect	B
27	MCPD - Other	Y
28	Auto Assigned-Redetermination	B
30	Voluntary county enrollment	N
31	Aprvd Chng-Recipient Choice Auto-assignment	B
33	Aprvd Chng-Untimely Communication	B
35	Aprvd Chng-PMP Panel Full	N
40	Aprvd Chng-PCCM PMP Disenrolled	B
41	Aprvd Chng-RBMC PMP Disenrolled	B
42	Aprvd Chng-Error in Assignment	B
43	Aprvd Chng-MCO Ancillary Service Access Issues	B
44	Aprvd Chng-PCCM Ancillary Service Access Issues	B
46	Aprvd Chng-Third Party Liability	Y

(Continued)

Table 8.1 – Indiana*AIM* Auto-assignment Start/Stop Reason Codes

Number	Description	Code
50	Aprvd Chng-Inconvenient Location	B
51	Aprvd Chng-Recipient Moved	B
52	Aprvd Chng-Transportation Problems	B
53	Aprvd Chng-Appointment Delays	B
54	Aprvd Chng-Waiting Time	B
55	Aprvd Chng-Treatment by staff	B
56	Unsatisfactory Communication	B
57	Aprvd Chng-Unsatisfactory quality of care	B
58	Unsatisfactory emergency response	B
59	Aprvd Chng-Unable to obtain referral	B
60	Aprvd Chng-Insufficient after-hours coverage	B
61	Aprvd Chng-Physician no longer Medicaid	B
62	Aprvd Chng-Physician no longer in practice	B
63	Aprvd Chng-Physician/Patient rltnshp unacpt	B
64	Aprvd Chng-Med condition not approp to pvdr	B
65	Physician requests recip reassign	B
66	Aprvd Chng-Speclty not consistent with cond	B
67	Aprvd Chng-Preg-related ante-partum change	B
68	Aprvd Chng-Preg-related post-partum change	B
69	Aprvd. Chng. - Other	B
70	ICES County Change	B
71	Residency Change	B
72	Third Party Liability Issues	B
73	Continuity of Care Issues	B
74	Recipient Determined to be Illegal Alien	Y
75	Recipient Choice - Enrolled in HCBS Waiver Program	B
76	Recipient Choice - Ward or Foster Child	B
77	Network Limitations	Y
78	More than one RID # linked from ICES	B
79	Recipient in Hospice	Y
80	Recipient Ineligible Due To Age	Y
81	Eligibility was removed	Y
99	Open	Y

Member Assignment

Eligibility Re determination

Eligibility redetermination occurs at intervals determined by the DFC. Generally, children are granted continuous eligibility for a period of one year. Members whose IHCP eligibility is continuous and who do not change from a managed care aid category to a non managed care aid category, maintain the PMP relationship.

Members who have had a gap in IHCP eligibility or managed care eligibility are processed as new members for auto-assignment purposes. That is, they are given 30 days to choose a PMP. If a PMP selection is not made at that time, the member is auto-assigned according to the criteria outlined. A previously enrolled Hoosier Healthwise member who does not make a PMP change would be auto-assigned to the previous PMP, if appropriate, to maintain that relationship. A redetermined member may make an authorized change at that time.

Member Request to Change PMP

Members may request a PMP change at any time for just cause, as outlined in the broad categories below, or for any reason at the time of eligibility redetermination. Substantiated acceptable reasons for requesting a PMP change include:

- Access to care
  - Member moved out of area
  - PMP's office not accessible on public transportation or an IHCP-reimbursable transportation provider not available in the service area
  - Waiting time in the office of one hour for a scheduled appointment on two occasions
  - Excessive delay between request for appointment and scheduled appointment
  - Difficulty in contacting the PMP for care after normal business hours
- Continuity of care
  - Member has an ongoing relationship with a PMP other than the PMP to whom the member is currently assigned
  - Current PMP disenrolls from the Hoosier Healthwise program
  - Member is in late stages of pregnancy and wishes to continue care with the current doctor through the pregnancy

- Quality of care or service
  - Member dissatisfaction with treatment by doctor or staff
  - Specialty services required due to language, cultural, or other communication barriers with current PMP
  - Ongoing, unresolved provider or member conflict
  - Member no longer fits into provider's scope of practice
- Auto-assignment
  - Member was auto-assigned to a PMP
- Other
  - Detailed explanation must be submitted in writing, reviewed, and approved on a case-by-case basis

The enrollment broker, Lifemark, maintains responsibility for administering and approving PMP change requests through the Hoosier Healthwise Helpline at 1-800-889-9949. The OMPP retains ultimate authority for approval of change criteria and for allowing PMP changes outside the approved guidelines when warranted by unusual circumstances. Participants who have frequent PMP changes or who alternate frequently between MCO and Prime*Step* providers are monitored by the OMPP, and such activity is addressed.

MCOs have the responsibility of approving PMP changes within their own networks. These changes must be forwarded to Lifemark to enter. Lifemark enters the change into Indiana*AIM*. While the PMP change reasons outlined above are specific to the Prime*Step* network, MCOs are encouraged to monitor PMP change activity within their networks, providing some degree of consistency with the Prime*Step* change policy.

Provider-Initiated Requests for Member Reassignment

The goal of the Hoosier Healthwise program is to encourage a positive and continuous relationship between members and PMPs; however, in rare instances, a PMP may request reassignment of a member to another PMP. These situations must be documented for reasons such as the following:

- Missed appointments, with appropriate documentation and criteria
- Member fraud; upper-level review required
- Uncooperative or disruptive behavior resulting from the member or member's family; upper-level review required
- Medical needs could be better met by a different PMP; upper-level review required

- Breakdown in physician and patient relationship; upper-level review required
- Member accesses care from providers other than the selected or assigned PMP; upper-level review required
- Previously approved termination
- Member insists on medically unnecessary medication

Unacceptable Reasons for PMP-Initiated Member Transfer Requests

- *For good cause* – This term is used for member-initiated PMP change requests
- *Noncompliance with mutually agreed upon treatment* – Members are not reassigned for being noncompliant or refusing treatment. A patient has the right to refuse treatment.
- *Demand for unnecessary care* – A PMP-initiated request for member reassignment will not be approved for this reason unless there is documentation of threatening, abusive, or hostile behavior as described.
- *Language and cultural barriers* – Members are not reassigned due to PMPs having difficulty with a member's language or other cultural barriers.
- *Unpaid bills incurred prior to Hoosier Healthwise enrollment* – Payment is guaranteed for care rendered during enrollment in the Hoosier Healthwise program. PMPs should pursue outstanding charges incurred **before** Hoosier Healthwise enrollment through the normal collection process.
- *Other enrolled members as determined by the OMPP*.

Member Lock-In

The federal *Balanced Budget Act of 199*7 allows Medicaid programs the option of extending lock-in periods up to 12 months. However, if a state elects to implement a 12-month lock-in, certain other requirements apply such as members must be allowed to change managed care entities for cause at any time within the first 90 days of enrollment for no reason, and the members must be notified, at least 60 days prior to the end of the enrollment year, of their opportunity to change after 12 months. The definition of *managed care entity*, as applied to Hoosier Healthwise, is an MCO or a Prime*Step* PMP.

The OMPP, after much discussion and deliberation in the middle or late in the calendar year 2001, has elected to not implement a PMP

Plan lock-in at this time. MCOs should, however, continue to educate members on the importance of a medical home and encourage members to maintain their PMP relationship. All MCOs and the Enrollment Broker are responsible for tracking PMP change reasons for potential quality improvement opportunities and should use member requests to change PMPs as an education or intervention opportunity.

Member Disenrollment from Hoosier Healthwise

The following are reasons why a Hoosier Healthwise member can be disenrolled from the IHCP and Hoosier Healthwise programs:

- Member was enrolled in error or due to data entry error
- Member loses eligibility in IHCP

An MCO enrollee can disenroll from an MCO network and retain eligibility in the Hoosier Healthwise program. Member disenrollment from an MCO network with enrollment into another Hoosier Healthwise network occurs under any of the following circumstances:

- The member selects a PMP that is not in the MCO network
- The member selects a PMP with an open program segment in a different network
- The member's PMP disenrolls from the MCO network and is available to Hoosier Healthwise members in another network
- The disenrollment is approved by the OMPP due to circumstances that, in the judgment of the OMPP, are justified and documented.

Some instances may warrant a member's disenrollment from the Hoosier Healthwise Managed Care Program, while eligibility is maintained in another IHCP component. It is important to program integrity that criteria used to make this determination are valid reasons for disenrollment and are applied consistently for all program enrollees. Lifemark approves, monitors, and tracks all member disenrollment activity for quality improvement through its Hoosier Healthwise Helpline at 1-800-889-9949. The OMPP has ultimate authority for allowing eligible members to disenroll from the program.

Examples of acceptable reasons for member disenrollment from the Hoosier Healthwise Managed Care Program to participate in another IHCP program include but are not limited to the following:

- *Member is determined to be ineligible* for the program under the terms of the State of Indiana *1915(b) waiver*.

- *Change in aid category* causes enrolled member to become ineligible for managed care.
- *Residency change* causes enrolled member to become ineligible for managed care. Hoosier Healthwise members who have out-of-state addresses are identified on a monthly report produced by EDS. The report is forwarded to Lifemark, which manually disenrolls the members. The former Hoosier Healthwise members may retain IHCP eligibility during a defined notification period as required in the IAC. Disenrollment from Hoosier Healthwise prevents further payment of administrative fees and capitation during this notification period.
- *Enrolled member meets long-term care criteria as determined by the Indiana Pre-Admission Screening and the Federal Pre-Admission Screening (IPAS/PASRR) processes.* Hoosier Healthwise members who are in a long-term care facility for more than 30 days may be disenrolled from the program because MCOs are not financially responsible for long-term facility care. After a member has met IPAS/PASRR, the appropriate level of care is entered into Indiana*AIM*, and the member is disenrolled from Hoosier Healthwise. Long-term care facilities must notify the MCO immediately after becoming aware of an MCO enrollee who is undergoing the screening process for long-term admission. The MCO must instruct Lifemark to disenroll the member at the end of the month. The MCO is financially responsible for all ancillary services and hospital care until the disenrollment is effective. The IHCP fee-for-service is financially responsible for all long-term care charges, excluding ancillary services, if the member meets the criteria for long-term level-of-care. MCOs should monitor the care of members who may be potential candidates for long-term care so they can help facilitate disenrollment from managed care. The MCO should work with the facility to ensure that the level of care process is completed, (for example submit the 450B), otherwise the member may be re-enrolled into managed care due to incomplete documentation for level of care.
- *Enrolled member is a ward or foster child* whose legal guardian requests disenrollment from the program. Wards and foster children in aid categories MA 3 and MA 4 may select a PMP and participate in the Hoosier Healthwise program on a voluntary basis. Wards and foster children who are in other aid categories may be auto-assigned in the Hoosier Healthwise program and should be encouraged to remain in the program when feasible. Members who may be placed in group homes within Indiana or out-of-state should be disenrolled from Hoosier Healthwise on request to facilitate access to care in the current setting.

- *Enrolled member becomes eligible for and enrolls in a HCBS waiver program*. Hoosier Healthwise members may become eligible for HCBS waiver services. Since IHCP enrollees may participate in only one waiver program at a time, Hoosier Healthwise members who participate in another waiver program may request disenrollment from Hoosier Healthwise. MCOs that become aware of this circumstance should contact the Hoosier Healthwise Helpline at 1-800-889-9949 to begin the disenrollment process.
- *Enrolled member becomes eligible for and enrolls in the IHCP Hospice program.* To receive hospice benefits, a member must elect hospice services, the attending physician must make a certification of terminal illness, and a plan of care must be in place. At the time a Hoosier Healthwise member elects to enroll in the IHCP Hospice program the member must be disenrolled from Hoosier Healthwise so the appropriate level of care can be entered in Indiana*AIM*. The hospice analyst at HCE requests that Lifemark immediately disenroll the Hoosier Healthwise member. Lifemark notifies the MCO and the PMP in writing of the member's disenrollment effective the day following MCO and PMP notification. This process ensures that both the MCO and the hospice providers have an accurate effective date on which to end or begin services.
- *Enrolled member who becomes eligible for Medicare* is no longer eligible to participate in the Hoosier Healthwise program. EDS identifies these members in a monthly report that is forwarded to Lifemark to complete the disenrollment process.
- *Member who has other medical coverage in a managed care plan* may be required to select a primary care physician (PCP) in that network. If the PCP in the commercial network is not in a Hoosier Healthwise network and coordination of benefits is not appropriate due to a documented reason or circumstance, the member may be disenrolled from Hoosier Healthwise and placed in the IHCP fee-for-service program.
- *Enrolled member who is determined to be an undocumented person* is limited to emergency services under IHCP Package E. Because the Hoosier Healthwise Managed Care Program promotes a full range of preventive and health care services, it is neither cost-effective nor within the program's stated goals to provide limited services. Undocumented recipients of care are excluded from the Indiana*AIM* auto-assignment process described previously. Occasionally, undocumented status is determined after a member has been enrolled in the program. EDS identifies these members on

a monthly basis and forwards a report to Lifemark to disenroll them from Hoosier Healthwise.

- *Other enrolled members as determined by the OMPP.*

Monitoring and Quality Control

One of the unique characteristics of Hoosier Healthwise is the process where eligible members are matched with appropriate PMPs. Many variables are considered, including the member's age, sex, and place of residence, and the PMP's specialty, panel size and practice location. Because of the complexity of this process, the Managed Care Unit has a procedure to check a random sample of 40 Hoosier Healthwise members for auto-assignment accuracy, appropriateness, and timeliness.

Members to be verified are randomly drawn from CRLD reports *MGD 0004* (RBMC) and *MGD 0005* (PCCM), and are checked for auto-assignment reasons that may include the following logic; previous PMP, default, case, newborn, redetermined, and RBMC disenrolled. Auto-assignments that fall outside this logic are reviewed by an SE if Managed Care specialists cannot identify the cause.

Eligible vs. Enrolled Report

The *Eligible vs. Enrolled* report is created on or near the first business day of the month. The report, described in detail in *Section 12: Reports*, compares the number of members eligible for Hoosier Healthwise managed care enrollment, the number actually enrolled, and the number linked to a PMP with a future date. This report monitors auto-assignment activity for a specific month and over time.

Section 9: MCO Orientation

Overview

All Hoosier Healthwise contractors may be asked to participate in the orientation of a newly contracted Hoosier Healthwise MCO. The extent of EDS' involvement in this process is determined by the OMPP. At a minimum, EDS will be requested to provide information that includes the following:

- *IHCP Provider Manual* – This provider manual is the primary reference for submitting and processing IHCP claims, prior authorization requests, and other related documents. It contains detailed instructions for claims submission and is the first referral source for answers to policy and procedural questions. One *IHCP Provider Manual* is issued at no cost to each provider upon enrollment in the IHCP. The provider must be active on the IHCP master file. Additional copies may be requested by contacting EDS Customer Assistance at (317) 655-3240 or 1-800-577-1278. To obtain additional copies of the manual, enrolled Medicaid providers can purchase them for $35 each. Nonproviders can purchase provider manuals for $50 each. The *IHCP Provider Manual* can also be obtained from the Web site at www.indianamedicaid.com.
- *Electronic Claims Capture Batch Claims Submission Technical Reference Manual* – This user manual assists software vendors and application programmers in preparing their systems to meet the *technical* requirements of the IHCP. This document includes setup, testing, communication requirements, and record layouts. This manual exclusively discusses the requirements for batch claim submission. A copy of this manual is available from the EDS Electronic Claims Submission group.
- Sender IDs for electronic claim submissions – Electronic billers must be properly certified before submitting claims electronically. Each provider must complete two separate forms to begin the enrollment process. These forms can be obtained by requesting an electronic claims packet through the Client Service Unit's customer assistance phone line or by contacting the EDS NECS help desk at (317) 488-5160. The ECC Setup Procedures are in the ECC Manual.
- *Claims Resolutions Manual* – Claim resolution editing and auditing validates information specific to a member's IHCP eligibility, subprogram affiliation, and claim history. These edits and audits are designed to support state and federal program requirements for

benefit limits and conditions of payment and are described fully in the *Claims Resolutions Manual*. System edits and audits are designed to cause a fee-for-service claim to suspend for review, pend for additional information, or deny. For shadow claims, claims are subjected to the same editing and auditing criteria for data collection, utilization, and program comparison purposes. Generation of the fee-for-service edits and audits in shadow claims processing causes claims to pay or deny in Indiana*AIM*. Shadow claims are not suspended or pended for review because these claims have been adjudicated by the MCOs with their contractors.

- Pricing information – When managed care entities develop systems to process their internal claims, they require certain nonproprietary information from EDS. The *Pricing Manual* describes how pricing will work in Indiana*AIM* with both new and old pricing methodologies. The claims pricing process determines–based on defined criteria–the pricing methodology applied to each claim based on one or more of the following: claim type, procedure specific pricing indicator, provider specialty, dates of service. The claim pricing process calculates the Medicaid-allowed amount for claims based on claim type and defined pricing methodologies. A current copy of the *Pricing Manual* is provided to the managed care entities upon enrollment and with subsequent manual updates.
- Fee schedules
- File formats for capitation, TPL and enrollment roster files, provider network file
- Schedule and procedures for submission of test files for all electronic transmissions
- IHCP provider update bulletins
- MCO enrollment information and procedures – Upon the execution of a contract between the IFFSA and the MCO, the IFSSA submits a written request to EDS to enroll the MCO in Indiana*AIM*. This notification includes the MCO name, address, contract name, telephone number, EFT information, ECS information, tax information, and negotiated capitation rates by region. EDS sends confirmation letters to the IFSSA and to the MCO. The letter contains the MCO's unique identification number composed of nine digits and one alphabetic character, for example, 999999999X. The alphabetic character denotes the region of the state where the MCO is enrolled, for instance North, Central, and South. If the MCO is enrolled in more than one region, the ID number remains the same with only the alphabetic character changing for each region where the MCO provides services.

- Network PMP enrollment procedures – PMPs in the Hoosier Healthwise Managed Care Program must be IHCP-enrolled providers whose primary practice is one of the following: general practice, family practice, general internist, pediatrics, or obstetrics/gynecology. The IHCP-enrolled provider must submit a Hoosier Healthwise PMP enrollment addendum to enroll as a network PMP. The signed and dated addendum must contain information including the specialty, intended scope of practice, service location(s) address (including 24-hour phone number), group affiliations (if applicable), and maximum panel size. The network submits the completed addendum and its PMP enrollment summary sheet to the EDS Managed Care Unit, where the IHCP provider is enrolled in Indiana*AIM* as a PMP.
- If the PMP is to be enrolled in an MCO network, the MCO submits the PMP enrollment summary sheet with a cover letter signed by a representative of the MCO.
- Network PMP disenrollment procedures – Hoosier Healthwise PMP Disenrollment Policies and Procedures.
- Schedules of financial cycles for capitation payments – EDS generates monthly capitation payments to the MCO account identified on the EFT statement included with the initial MCO enrollment. This transfer occurs during the first financial cycle following the 15th day of the month. EDS posts the capitation roster to the ECC bulletin board and generates a capitation tape on a 3480 cartridge by MCO and region. A schedule of actual capitation payment dates is distributed to the MCOs at the beginning of each calendar year.
- Format for monthly managed care meetings – A meeting, facilitated by EDS, is held monthly on the second Thursday of each month to provide a forum for discussion of new Hoosier Healthwise program policy and clarification of existing policy. Each meeting follows a prepared agenda with all items summarized as attachments to the agenda. Each potential agenda item is submitted to the EDS Managed Care team lead by noon one week and one day prior to the scheduled monthly meeting date. EDS prepares the agenda with attachments and distributes it to attendees one week prior to the meeting date.

Section 10: Quality Improvement

Overview

The Managed Care Unit and the Indiana Title XIX account are committed to providing the highest level of quality service to their customers. The Unit's approach to management focuses on optimizing overall quality performance through the use of continual improvement principles, methods, and tools.

The Indiana Title XIX Managed Care Unit operates in compliance with requirements set forth in a State-issued Request for Proposal. There are 50 managed care-specific contract requirements; all of which are encompassed within the Managed Care Unit's standard business functions.

The Managed Care Unit, for every business function, has developed a quality assurance and improvement plan. Each function and process is documented in detailed flowchart format. All outputs are checked for accuracy, and data is monitored routinely for statistical indicators and improvement opportunities. The Managed Care Unit staff integrates continual quality improvement discussions into the weekly unit meetings. Agenda items routinely include sharing and discussion of data, improvement initiatives, and potential improvement ideas, as well as ongoing *SOPK* (System of Profound Knowledge) training. The detailed quality assurance and improvement plans, specific to each Managed Care Unit function are described in detail within the associated section of this manual.

One RFP requirement pertains directly to the implementation of a Managed Care Unit Quality plan. The related RFP requirement follows:

- MCC-5: Provide quality assurance procedures to ensure that Indiana*AIM* produces information, data, and reports accurately, on time, and in a format that is easily understood.

Processes

Statistical Process Control Methods/Process Behavior Charts

Measuring a process is important in determining its capability. This is the critical first step in making management decisions based on data as

opposed to *hunches* or *gut instinct.* This data is the voice of the process and provides management with a visual tool to determine when problems exist or if a change made was a true improvement.

Two types of process behavior charts used for Statistical Process Control (SPC) are commonly used by the Managed Care Unit. These are the **X Chart** and the **Pareto** chart. To determine SPC, the Process Behavior Chart is calculated from the actual data collected for the process or requirement. This data is usually gathered daily, weekly, or monthly depending on the process.

X Chart

The most common process behavior chart used is the **X** Chart. An example of this chart is shown in Figure 10.1. This chart contains an Xbar or average, which is the average of all the data points. Surrounding the Xbar are two lines on the chart representing an upper and lower control limit. These control limits, like the Xbar, are set by the actual data. When reading the chart, Managed Care Unit staff looks to see if the process is in control. The process is in control if all data points are between the upper and lower control limits. An out of control process occurs when one or more data points fall outside of the control limits. This is called a s*pecial cause*. Those s*pecial cause* data points are investigated to determine what caused the data to shift or become out of control.

An **X** Chart provides a visual representation of the data. It allows management to quickly determine the s*pecial causes* in a process to eliminate them. The charts also show trends or processes that have shifted up or down.

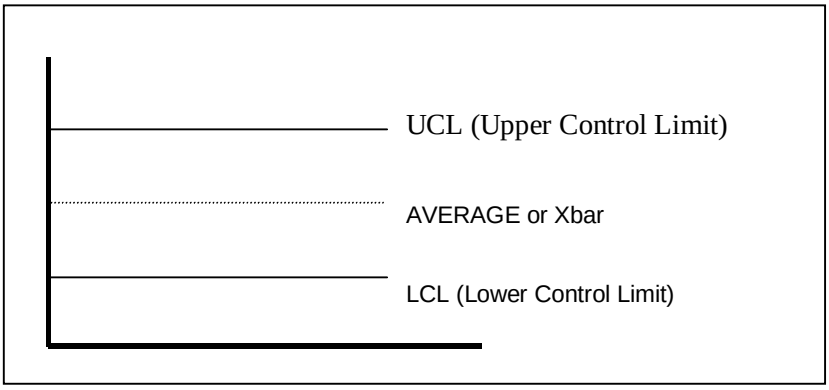


Figure 10.1 – Example of an X Chart

General Instructions for Creating X Charts:

1. Open the X chart macro workbook—click **Open** and click **Enable Macros**
2. Go to the X Data tab and verify there are enough rows to enter data
   - If more rows are needed, go to the X Bar tab and press and hold **Ctrl** while clicking each tab over to the end
3. Go back to the X Data tab and add the new rows needed above the asterisk on the worksheet
4. Before entering data in the columns on the X Data tab worksheet, remove the highlight placed on the tabs to insert new rows
5. Once data is updated, click **Tools,** click **Macro,** and click **Macros** (the macro named XmovR should be in the run box)
6. Click **Run** and the X chart is created

Pareto Chart

The second type of process behavior chart used by the Managed Care Unit is called a Pareto chart. The Pareto clearly illustrates the most frequent item(s) and allows management to focus on the most critical elements of a process. The bar graph at the bottom of Figure 10.2 displays the count and percent of each type of data. It gives management a visual communication of occurrences or frequency of the item measured. The dotted line at the top of the Pareto chart is the cumulative percentage and always ends at 100 percent. The most important items to consider in a Pareto chart fall on the left side of the chart. The most infrequent items or occurrences fall on the right of the chart.

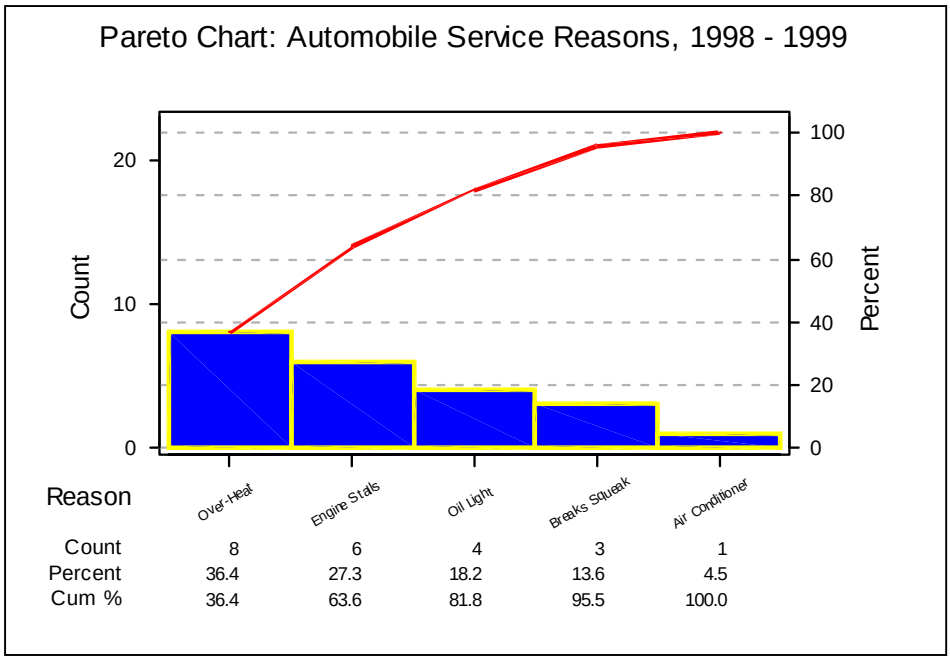


Figure 10.2 – Example of a Pareto Chart

This Pareto chart example represents the most common reasons for an automobile needing a service repair. The bottom left of the chart shows the most frequent or common occurrence (overheating). This problem occurred eight times and represented 36.4 percent of the total car problems for the year. The second occurrence (engine stalls) happened six times over the year accounting for 27.3 percent. The cumulative of the two most frequent problems accounted for 63.6 percent of the car problems.

General Instructions for Creating Pareto Charts:

1. Open the Pareto chart
2. Click **Current Data Window** tab and type the data into applicable columns
3. Click **Stat** from the tool bar and click **Quality Tools** on the drop-down menu
4. Click **Pareto Chart** and click **Chart Defects Table** and place the columns updated into the frequencies box
   - Make sure the combine defects box has 99 in it and change the title box if needed
5. Click the **OK** tab and the macro creates the Pareto chart

Key Measures

At the beginning of the Managed Care Unit's Continual Improvement process, the unit developed a shared aim that includes the Managed Care Unit-specific mission, vision, values, and key measurements. Part of the aim development process included looking at the customers who are served and the outputs associated with these customers. Once the aim was developed, key measurements were identified that show performance at the operational level. These key measurements are continually monitored to determine the *health* of the overall system, as each of the individual key measurements relates to the whole. The Managed Care Unit's mission is to support the Hoosier Healthwise program with quality data, analysis, and proactive pursuit of issue identification and resolution. Managed Care Unit measures several processes, including these key items:

- Managed Care Issues
- Managed Care Claim Edit Activity
- PMP Enrollment and Panel Statistics
- Member Enrollment
- Capitation Payments

Managed Care Issue Log

The Managed Care Unit is the contact point for resolution of many issues related to the Hoosier Healthwise MCO and PCCM programs. Tracking of program issues identifies areas of highest concern or attention. The *Managed Care Issue Report* is published quarterly and provides detailed narrative about both broad issues related to managed care, as well as the status of current operational issues and recommendations to resolve them.

There are 9 issue types identified on the Managed Care Unit's *Issue Log*. The data from the log is quantified and identifies trending of the vital issues facing the Managed Care Unit. Pareto charting identifies the top issues addressed by the Managed Care Unit. The issues most vital to the customers of the managed care program, once targeted for resolution, are assessed for anticipated results by using the X Chart. X Charts are created for each comprehensive issue type on which the Managed Care Unit is focusing research efforts, or for which the Managed Care Unit is developing process improvement plans. Routine reporting on the Managed Care Unit's accomplishments as they pertain to these requirements is included in the *Managed Care Quarterly Issue Report* and the *Contract Monitoring Monthly Report*.

Managed Care Claim Edit Activity

The Managed Care Unit monitors the daily process behavior of Managed Care Edits *342, 343, 1011, 2017*, and *2018* by claim type.

Edits with an occurrence value greater than 10 are systematically generated each day at 9:30 p.m. and forwarded by e-mail to the Managed Care analyst for control charting.

Reporting Managed Care edit activity includes process behavior charting, notation of exception indicators or process behavior (data) shifts, and research results. The Managed Care analyst reports occurrences of data shifts and exception points to the rest of the Managed Care team as soon as the shifts or points are identified. The team may readily recognize that a *special cause* situation created the exception, or they may initiate further research to determine the cause. This type of data monitoring is expected to *red-flag* defects and breakdowns in upstream processes such as reference file updates and certain system changes. Routine reporting of data activity and investigative results is included in the *Managed Care Quarterly Issue Report* and the *Contract Monitoring Monthly Report*.

Program Health Monitoring

QI Data Grid information, along with MAR information and CRLD Financial information is gathered and compiled, on a monthly basis, for the purposes of process behavior charting and monitoring the health, over time, of the Hoosier Healthwise Managed Care Program. Each quarter, a different aspect of the program is reported in the *Managed Care Quarterly Issue Report* and the *Contract Monitoring Monthly Report*.

Control charting of this type of managed care data, and comparison to IHCP totals, is completed to assist the OMPP with the monitoring of the Hoosier Healthwise program status and change over time, and to determine the effects of policy or procedural changes to the program components. The 2002 mandatory MCO transition is a good example of a programmatic project that deserved this type of monitoring effort.

Following are some of the components analyzed each month, along with some key points of consideration.

Hoosier Healthwise Process Data Behavior

1. How is the overall Hoosier Healthwise program progressing over time?
2. Are the number of members and PMPs increasing at a steady rate, or is the program leveling off?
3. What changes in data behavior are evident with program implementation and changes?
4. Is the ratio of members to PMP remaining healthy?
5. What percentage of PMPs have Closed/Hold panels?

6. At what rate are members making PMP changes?

Member Data

1. What proportion of the IHCP member population is Hoosier Healthwise?
2. What is the relative enrollment in each of the managed care network programs, and how does the activity fluctuate and respond to changes in the program?

Financial Data

1. What proportion of the IHCP budget is Hoosier Healthwise? Is this percentage increasing or decreasing over time?

Shadow Claims

1. What is the relationship of claims to members?
2. What is the relationship of paid versus denied claims?

Potential Improvement Logs

Through the use of data-tracking tools, day-to-day business discussions, brainstorming, or program changes, ideas for process improvement may surface. Time and daily workload do not always allow these improvement ideas to be addressed when recognized, so these ideas are captured and documented on a *Potential Improvement Log* (*PI Log*) as illustrated in Figure 10.3. Improvement initiatives actively being addressed by the unit are documented on a *Unit Task List*.

Indiana Health Coverage Programs

P O T E N T I A L I M P R O V E M E N T S L O G

T E A M N A M E Y Y Y Y

	Date	Define the Improvement Effort and Why Change is Needed
1	MM/DD	
2	MM/DD	
3	MM/DD	

Figure 10.3 – Potential Improvement Log

Standard Formats for Agendas/Minutes

Meetings make up a significant portion of the Managed Care Unit's workday. Managed Care Unit representatives attend internal meetings and customer meetings to work through issues and to provide, as well as receive, information and education. The use of standard forms for meeting agendas and meeting minutes ensures the objectives planned for the meeting are covered, and that all important information and decisions are well documented for reference. Following are the standard agenda and meeting minute templates used.

Indiana Health Coverage Programs

M E E T I N G M I N U T E S

M E E T I N G N A M E M M M D D , Y Y Y Y – H : M M - H : M M

Meeting Minutes

Leader/Facilitator: _____ Scribe: _____

Location: _____

Attendees

List names of attendees below and mark absents (A)

_____ _____ _____

_____ _____ _____

Agenda Item	Topic	Notes (conclusions, discussions, decisions, and next steps)

Agenda Topics for next meeting

1.
2.
3.
4.

Next Meeting

Date: _____ Location: _____

Leader/Facilitator: _____ Scribe: _____

Figure 10.5 – Standard Meeting Minutes

Indiana Title XIX

A G E N D A

M E E T I N G N A M E M M M D D , Y Y Y Y F R O M H : M M - H : M M

F A C I L I T A T O R R O O M M E E T I N G N U M B E R

Planned		Actual Start	Agenda Item	Who	Topic/Methods
Min	Start				

Figure 10.6 – Standard Meeting Agenda

Section 11: Project Management

Overview

The Managed Care Unit team has processes and procedures for ensuring all projects are appropriately managed. All projects are assigned project leads who assume the role of project planners. Project leads develop work schedules and task assignments, as well as provide work leveling information by identifying requirements for additional resources. They also identify when adjustments in scheduling need to be made in order to meet target dates. The project leads also identify when additional resources are acquired or required to complete tasks. In addition to project planning, the project leads record all work effort; allow measurement against the plan; suggest when adjustments in the plan are required; provide long-term information on the outcome of the update process; and demonstrate level of progress on the update against identified target dates.

Processes and Procedures

Unit Task List

The *Unit Task List* is a project tracking tool used by all Managed Care Unit team members to monitor the progress and status of managed care CSRs and project tasks. The *Unit Task List* is updated weekly by the project lead with status date, next steps or estimated completion date (ECD), along with a brief summary of current status. Tasks are organized by sections. Active ongoing CSRs are listed in the first section. The second section is for CSR projects to be written and approved or prioritized. The third section is for other projects. The fourth section is for tasks on hold. The final section is for closed tasks. When entering a new task, the task leader logs the assigned control number, if applicable, the CSR number, if applicable, and the name of the task or CSR in the first block. The second block is for the project lead's name. The third block titled *Status* is for a brief description of the task or CSR. The final block is for the next steps, brief description of progress, and the current status. Tasks are updated weekly using the weekly status meeting date.

CSR Monitoring

The Managed Care Unit monitors all account CSRs for affects on managed care business processes or system functionality. Managed Care Unit team members are assigned subsystems to *watch* for CSR activity. These assignments can be found on the departmental system directory in the CSR monitor file located in the CSR folder. The *Weekly Status Report* provides a source where current Account CSR information can be obtained. A CSR affecting managed care is reported to fellow Managed Care Unit team members in the weekly Managed Care Unit Team Meeting. As long as the CSR is "active", the team member assigned to the particular subsystem monitors the CSR's progress, provides managed care feedback to the SE working on the CSR, and assists with any managed care-specific information or testing that is needed.

CSR Development

CSRs written by the managed care team members follow the guidelines in the following text that were developed by the team to ensure they are written accurately and clearly, and that minimum testing requirements are established.

Managed Care Unit CSR Project Management Guidelines

- Identify the business requirements for the CSR
  - Is the CSR a result of a customer request or an internally identified need?
  - What is the purpose and objective of the CSR?
  - Quantify how much time and money this CSR will save.
  - Identify if there is an alternate solution to developing a CSR; for example, ad hoc or other report.
  - Identify if other units will be affected by the CSR and seek their input.
- Analyze and understand the scope and implications of the customer's requirements.
  - Review with project leader and team members to ensure clarity and completeness.
  - Review with other units as appropriate.
  - Develop minimum model office test cases to submit with CSR (use Model Office Testing Guide template).
- Collect the information where the customer's requirements will be determined.
  - Use all appropriate techniques from Requirements Determination Process (RDP).
  - Flowchart the process or functionality that the CSR will change, enhance, or add, if appropriate.

  - Document the process used on the project task list.

- Develop CSR in Managed Care Unit.
  - Draft CSR mask
  - Develop personal project task list, including date started, sources used, date turned into Systems for review, and so forth.
  - Assign unit task control number and add task to the unit task list.

- Complete CSR mask draft and confirm mutual understanding of requirements with customer.
  - Review CSR mask with customer before submitting to the Systems Unit for approval and number assignment. Document date reviewed and comments received in project task list. Revise mask as needed.
  - Review with MCOs or enrollment broker, as appropriate, to ensure requirements meet MCOs needs and capabilities.
  - Resolve any issues prior to submitting to Systems. Rewrite mask as needed and as mutually agreed to with the OMPP. Document in project task list the dates information was shared with MCOs. Specify the individuals who reviewed draft CSR.

- Submit CSR mask draft to the Systems Unit.
  - Include any attachments, screen prints, and the minimum number of model office testing scenarios needed to adequately test.
  - Save CSR mask on *I:\CSR\Requests*, and specify on control log what CSR is named and where the mask is saved.
  - Follow-up with Systems twice monthly to determine when the CSR has been assigned a number and whether it has been prioritized by the OMPP.
  - Record activity in the project task list. Update the unit task list.

- Once the CSR is assigned a number and prioritized, follow up with Systems or leader monthly to confirm status and determine if an SE has been assigned.
  - Record all follow-up in the project task list and update the unit task list with progress.

- Once an SE is assigned, initiate a meeting with the SE to review requirements to ensure SE understands scope and purpose and to answer any questions.
  - Ask SE for high-level requirements and other CSR documentation as it's developed (for example, additional testing scenarios, post-implementation review plan).
  - Ask SE for estimated time frame for completion.
  - If it has been more than six months since the CSR was written and approved, have the customer and the Managed Care Unit review the CSR again to verify that it is still needed, wanted, and written appropriately for current reality.

  - Rework mask or cancel if needed.
- Follow up with the SE twice monthly to review status.
  - Record status in the Project Task List and the Unit Task List.
- Once coding is complete, review again the model office test plan with the SE. Enhance test plan or use as is, and have other team members' review again for completeness and appropriateness. Ask if the OMPP customer wants to review the test plan before testing begins.
  - Determine who is conducting testing – Systems or Managed Care Unit.
  - Collaborate with Systems on testing, testing review, and walkthrough.
  - Collaborate with Systems on post-implementation review.
  - Record all activity in the project task list.
- Evaluate the CSR project
  - Assess how well the RDP and CSR development process went for this project; discuss with BA and SE on the project.
  - Share successes and lessons learned with the team.
  - Record final activity in the project task list.
  - Record as an accomplishment on the weekly status report.
  - Record completion date on the Managed Care Unit control number log.

Project Task Plans

All large or time-intensive projects, as well as projects of a sensitive nature, are documented on project task plans by the project lead. The project task plan mask is on *L:/Manage Care/Managed Care Unitnit/ Projects/projmask.doc.* See *Appendix F: Project Task Plan Mask* for an example. The project task plan is assigned a control number from the Managed Care Unit's control number log located on *L:/Manage Care/ Managed Care Unitnit/Control#/Mclog.xls*. Project task plans are updated with project milestones along with processes and steps for completion either identifying the scheduled due date or the actual date delivered. The status of each project task plan is discussed with the project task leader and the Managed Care Unit director during monthly one-on-ones. In addition, project task plans that affect the customer are added to the *Unit Task List.* The status of the unit task list is updated weekly and reported to the OMPP during the biweekly EDS/OMPP status meetings.

Section 12: Reports

> *Note: Section 12 is in development and does not contain current information.*

Overview

The Managed Care Unit develops, prepares, analyzes, and distributes reports from several sources used to track and monitor the trends and outcomes of various aspects of the Hoosier Healthwise program. This section provides detailed information about the report definitions, media, frequency, distribution, and quality control measures for each report.

Quality Control Monitoring Reports

Currently, the Managed Care Unit produces the following quality monitoring reports. These reports monitor the Managed Care Unit's processes to verify everything is functioning according to design.

Managed Care Issue and Trend Monitoring

Managed Care Unit analysts record issues encountered daily into a spreadsheet named *Managed Care Issue Log*. Issues originate from a variety of sources including the OMPP, Lifemark, providers, and the MCOs. Recorded issues are categorized by type.

Control charting and analysis are performed monthly and quarterly to identify and quantify changes in process behavior. Pareto charting presents the relative contribution of each issue type to the whole, and X-Bar charting illustrates the process behavior of managed care issues over time. Means to resolve the issues most vital to the customers of the managed care program are identified and results are reported in the monthly *Contract Monitoring Report* and the quarterly *Managed Care Issue Report*.

Managed Care Edit Monitoring

The Managed Care Unit monitors the daily process behavior of managed care edits *342, 343, 1011, 2017*, and *2018*, by claim type. Edits with an occurrence value greater than 10 are systematically

generated each day at 9:30 p.m. and forwarded by e-mail to the Managed Care analyst for control charting.

Reporting managed care edit activity includes process behavior charting (X-chart), notation of exception indicators or process behavior (data) shifts, and research results. The Managed Care analyst reports occurrences of data shifts and exception points to the rest of the Managed Care team as soon as the shifts or points are identified. The team may readily recognize a *special cause* situation that created the exception, or they may initiate further research to determine the cause. This type of data monitoring is expected to *red-flag* defects and breakdowns in upstream processes such as reference file updates and certain system changes. Interesting or otherwise significant observations resulting from the data monitoring process are reported monthly in the *Contract Monitoring Report* and quarterly in the *Managed Care Issue Report*.

Hoosier Healthwise Process Behavior – QI Data Grid Control Charting

The Managed Care Unit derives data from the *QI Data Grid Report* to monitor the monthly process behavior of certain Hoosier Healthwise Managed Care Program indicators. X-Bar charting of high-level indicators graphically illustrates the health of the program over time and also provides a means for early detection of potential or impending problems. X-Bar charting is performed on the following indicators:

- Number of members
- Number of members disenrolled
- Number of members making PMP changes
- Number of PMPs
- Ratio of members to PMPs
- Number PMP disenrollments
- Percent PMPs with closed/hold Panels
- Number available panel slots per member enrolled

This process is currently used as an internal monitoring tool, and is not formally reported to outside entities. Reporting of these measures in the *Weekly Status Report* may be approved by OMPP in the future.

Ad hoc Reports

The ad hoc reports described below are produced in the Managed Care Unit by DSS queries. Detailed procedures for running the queries and moving the resulting data to report format are maintained by the Managed Care reporting specialist. In addition to the regular ad hoc reports described here, the Managed Care Unit may also produce other reports to analyze data or at the request of OMPP.

15th of the Month Report

Functional Area	Report Number	Job Name	Report Title
Managed Care	N/a	DSS	15th of the Month Report

Description of Information

These reports identify enrolled managed care members in both PCCM and an MCO who have an illegal aliens status, a ward indicator, open Medicare segments, open level of care segments, or an out of state address.

Purpose

These reports are forwarded to the enrollment broker and OMPP for review of members who should be disenrolled from managed care.

Sort Sequence

1. Reporting designation (alien, ward, Medicare, OOS, LOC)
2. Managed care program
3. Member last name
4. Member first name

Distribution

To	Media	Copies	Frequency
EDS - Martha Whiteman	E-mail	1	Monthly
OMPP - Marti Lowery	E-mail	1 (out-of-state only)	Monthly
Lifemark Corp. (Enrollment Broker)	E-mail	1	Monthly

Quality Measures

The Managed Care reporting specialist performs the following report validation steps to verify that the report data is accurate. A follow-up review of the report is completed by a designated quality reviewer, who spot checks the report for data accuracy and cosmetics prior to report distribution.

- Indiana*AIM* data correlation
- Verification of formulas and totals
- Comparison of data from previous months
- Formatting, typos, and spelling errors

Query Definitions

Queries	Current Purpose
Query 01	Identify members with alien status. Qualify IND_ALIEN = "I". Create temporary table A_ALIEN_BASE.
Query 02	Identify members with alien status, using A_ALIEN_BASE, who have a current managed care PMP assignment. Create temporary table A_ALIENS.
Query 03	Generate report data of managed care members with alien status.
Query 04	Identify managed care members with a current level of care segment. Create temporary table A-LOC.
Query 05	Generate report data of managed care members with a current level of care segment.
Query 06	Identify managed care members with Medicare. Create temporary table A_MEDICARE_BASE.
Query 07	Further qualify managed care members with Medicare. Create temporary table A_MEDICARE.
Query 08	Generate report data of managed care members with Medicare.
Query 09	Identify members with Hoosier Healthwise Package A and B aid categories (potential members): C, E, F, H, M, N, S, T, U, X, Y, Z, 1, 2, 3, 4, 9. Create temporary table A_WARDS_T1.
Query 10	Identify potential members, using A_WARDS_T1, who are currently enrolled in managed care. Create temporary table A_WARDS_T2.
Query 11	Identify members with Ward indicator, using A_WARDS_T2, who have a current managed care PMP assignment. Qualify CDE_WARD_TYPE <> "N". Create temporary table A_WARDS.
Query 12	Generate report data of managed care members with Ward indicator.
Query 13	Identify out of state members. Create temporary table A_OS_BASE.
Query 14	Identify out of state members, using A_OS_BASE, who are currently enrolled in managed care. Create temporary table A_OS.
Query 15	Generate report data of managed care members with out of state addresses.

Report Example

> *Note: Each of the reporting designation (alien, ward, Medicare, OOS, LOC) are reported separately. Package A and B are also reported separately from Package C within each of the reporting designations. The following report example for Hoosier Healthwise members in Package A and B, with Out- of-state address represents the standard reporting format of each of the reporting designations. Two exceptions to the standard formatting are: the inclusion of a level-of-care code and dates for the level-of-care reporting designation, and the inclusion of Medicare* effective *and* end dates *for the Medicare reporting designation.*

Hoosier Healthwise Members
Package A and B
* * * Out of State * * *
August 15, 2000

PGM	RID	LAST NAME	FIRST NAME	PROVIDER ID	EFF	END
Harmony	xxxxxxxxxxxxx	xxxxxx	xxxxxx	xxxxxxxxx	xxxxxxxx	xxxxxxxx
Harmony	xxxxxxxxxxxxx	xxxxxx	xxxxxx	xxxxxxxxx	xxxxxxxx	xxxxxxxx
				Harmony	Total	2
MHS	xxxxxxxxxxxxx	xxxxxx	xxxxxx	xxxxxxx	xxxxxxxx	xxxxxxxx
MHS	xxxxxxxxxxxxx	xxxxxx	xxxxxx	xxxxxxx	xxxxxxxx	xxxxxxxx
MHS	xxxxxxxxxxxxx	xxxxxx	xxxxxx	xxxxxxx	xxxxxxxx	xxxxxxxx
				MHS	Total	3
MDwise	xxxxxxxxxxxxx	xxxxxx	xxxxxx	xxxxxxx	xxxxxxxx	xxxxxxxx
MDwise	xxxxxxxxxxxxx	xxxxxx	xxxxxx	xxxxxxx	xxxxxxxx	xxxxxxxx
MDwise	xxxxxxxxxxxxx	xxxxxx	xxxxxx	xxxxxxx	xxxxxxxx	xxxxxxxx
MDwise	xxxxxxxxxxxxx	xxxxxx	xxxxxx	xxxxxxx	xxxxxxxx	xxxxxxxx
				MDwise	Total	4
PCCM	xxxxxxxxxxxxx	xxxxxx	xxxxxx	xxxxxxx	xxxxxxxx	xxxxxxxx
PCCM	xxxxxxxxxxxxx	xxxxxx	xxxxxx	xxxxxxx	xxxxxxxx	xxxxxxxx
PCCM	xxxxxxxxxxxxx	xxxxxx	xxxxxx	xxxxxxx	xxxxxxxx	xxxxxxxx
PCCM	xxxxxxxxxxxxx	xxxxxx	xxxxxx	xxxxxxx	xxxxxxxx	xxxxxxxx
PCCM	xxxxxxxxxxxxx	xxxxxx	xxxxxx	xxxxxxx	xxxxxxxx	xxxxxxxx
				PCCM	Total	5
				Grand	Total	14

Figure 12.1 – Example of Managed Care 15th of the Month Report

Eligible vs. Enrolled Report (Package A and B)

Functional Area	Report Number	Job Name	Report Title
Managed Care	N/a	DSS	Eligible vs. Enrolled (Package A & B)

Description of Information
In development

Purpose
In development

Sort Sequence
County code

Distribution

To	Media	Copies	Frequency
EDS - Martha Whiteman	E-mail	1	Monthly
OMPP Managed Care Director	E-mail	1	Monthly
Lifemark Corp.	E-mail	1	Monthly

Quality Measures

The Managed Care reporting specialist performs the following report validation steps to verify the report data is accurate. A follow-up review of the report is completed by a designated quality reviewer, who checks the report for data accuracy and cosmetics prior to report distribution.

If a significant gain is noted for eligible members on the potential table that is greater than 30 days, the reporting specialist performs a detail analysis, reviewing aid categories of potential members, age, sex, and PMP availability in counties.

- Indiana*AIM* data correlation
- Verification of formulas and totals
- Comparison of data from previous months
- Formatting errors
- Typos and spelling errors

Column	Column Definition
Column 05	Number of members with a current PMP assignment
Column 06	Number of members with future assignment
Column 07	Number of mandatory enrolled members
Column 08	Percentage of mandatory enrolled members (column 7) divided by the net eligibles (column 4)
Column 09	Number of voluntary enrolled members. Voluntary enrollment is determined by an aid category MA3, MA4, or aid categories C, E, F, H, M, N, S, T, U, X, Y, Z, 1, 2, 3, 4 9 whose ward indicator is yes, ward for CHINS, court order or parent term.
Column 10	Eligibles

Report Definition as of August 14, 2000

1. This monthly report reflects a count by county of **net** eligible members (Column 4) with the previously mentioned aid categories who are 64 and younger. This net eligible count excludes members (Column 3) of the previously mentioned aid categories with the following factors:
   - Members with a current Medicare segment
   - Members 65 and older
   - Members with a current level-of-care segment
   - Members who are identified as illegal aliens.
   - Members whose state address is not Indiana
   - Enrolled members are members (Column 5) who have a current PMP assignment

   Note: This count could include members who, subsequent to their PMP linkage, had an eligibility status change and who now need to be disenrolled. These members appear on the 15th of the month reports.
2. Column 6 shows a count by county of future assigned members.
3. Column 7 shows a count by county of mandatory enrolled members..
4. Column 8 shows the percentage of mandatory enrolled members by county. The formula is Hoosier Healthwise Mandatory Enrolled Members/Hoosier Healthwise Eligible Members X 100. This is the percentage by county. This data is displayed in column 6 of the current report.

(Continued)

Report Definition as of August 14, 2000

5. Column 9 shows a count by county of the voluntary enrolled members. Voluntary enrolled members are MA 3 (Wards not IVE eligible under 18) no matter what their ward indicator shows) MA 4 (Title IVE Foster Children under 18) no matter what their ward indicator shows and Aid Categories C, E, F, H, M, N, S, T, U, X, Y, Z, 1, 2, 3, 4, and 9 whose ward indicator shows the following:
   - Yes
   - Ward indicator for Chins
   - Court order
   - Parent termination

6. This monthly report identifies the number of eligible members on the potential table 30 days or less by county. The data is shown in column 10 of the current report. Excluded from this count are potential members who are the following:
   - P (Package C has a separate Eligible vs. Enrolled Report).
   - B (Self-selecting potential members; for example, MA3 and MA4 and all wards not in those aid categories)
   - Aid Categories C, E, F, H, M, N, S, T, U, X, Y, Z, 1, 2, 3, 4, and 9 whose potential members' ward indicator shows the following:
     - Yes
     - Ward indicator for Chins
     - Court order
     - Parent termination

7. This monthly report also identifies the number of eligible members on the potential table over 30 days by county. The data is shown in column 11 of the current report. Excluded from this count are potential members who are the following:
   - P (Package C has a separate Eligible vs. Enrolled Report).
   - B (Self-selecting potential members; for example, MA3 and MA4 and all wards not in those aid categories)
   - Aid Categories C, E, F, H, M, N, S, T, U, X, Y, Z, 1, 2, 3, 4, and 9 whose potential members' ward indicator shows the following:
     - Yes
     - Ward indicator for Chins
     - Court order
     - Parent termination

8. Column 12 identifies by county the number of potential members who may self-select (reason code of B) and have been placed on the potential table 30 days and less. These potential members are as follows: B (Self-selecting potential members; for example,. MA3 and MA4).

(Continued)

Report Definition as of August 14, 2000

9. Column 13 identifies by county the number of potential members who may self-select (reason code of B) and have been placed on the potential table over 30 days. These potential members are as follows: B (Self-selecting potential members; for example, MA3 and MA4)
10. Column 2-10 have statewide totals. Please note column 8 has a statewide percentage of Hoosier Healthwise Enrolled Members/Hoosier Healthwise Eligible Members X 100. This percentage is reflected at the end of column 8 in the current report.
11. Each column has a row at the end of the report to show the total previous month's data for that column.

    Each column has a row at the end of the report to show the gain/loss of the current month reporting from the previous month.

Aid Categories Legend

Aid Category	Description
1	Children age < 19 who meet TANF income stds
2	Children ages 6-19 under 100% FPL
3	Wards not IVE eligible under 18
4	Title IVE foster children under 18
9	Children age 1-19 up to 150% poverty (CHIP I)
C	Low Income Families
E	Extended Eligibility for Pregnant Women
F	Transitional Medical Assistance
H	Ineligible for AFDC due to deemed income
M	Pregnancy - Full Coverage
N	Pregnancy - Related Coverage
S	Ineligible for AFDC due to sibling income
T	Children age18,19,20 living w/specified relative
U	Ineligible for TANF due to SSI payments
X	Newborn - infants born to Medicaid recipients
Y	Children age<1 under 150% FPL
Z	Children ages 1-5 under 133% FPL

Potential Table Reason Codes

Reason Code	Description
P	Package C
B	Pending for manual assignment (*designated for MA3 and MA4)
C	BA assistance required (assigned when system cannot make an auto-assignment)

Distribution List

Name	Organization	Method
Jeanne Lewer	EDS	Hard Copy
Managed Care Director	OMPP	E-mail or Courier
Lynn Irelan	MCS	E-mail

Quality Measures

The quality specialist looks at data from six months prior to see if a significant gain is noted for eligible members on the potential table greater than 30 days. If a gain is noted, report is created reviewing the top six counties. Detail analysis is done reviewing the potential members aid categories, age of potential member, sex of potential member, and PMPs availability in county. The data is reviewed in Indiana*AIM*. The quality reviewer, after the report is completed, reviews the data for these quality elements:

1. Verification of formulas and totals of report
2. Comparison of data from previous months
3. Formatting errors
4. Typos and spelling errors

Columns in Current Report

County (column 1)	Members with the Package A & B Aid Categories (column 2)	Ineligible Members (column 3)	HH Package A & B Eligible Members (column 4)	HH Package A & B Enrolled Members (column 5)	Pending Enrolled Members (Future Assignment Dates) (column 6)	Mandatory Enrollment (column 7)	HH Percentage Mandatory Enrollment (column 8)	Voluntary Enrollment (column 9)	Eligible Members on Potential Table (Mandatory Enrollment)		Self Selected Eligible Members on Potential Table (Voluntary Enrollment)	
									30 DAYS OR LESS (column 10)	OVER 30-DAYS (column 11)	30 DAYS OR LESS (column 12)	OVER 30-DAYS (column 13)
STATEWIDE TOTALS	xxx	xxx	Xxxxxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx
CHANGE FROM PRIOR MONTH	xxx	xxx	Xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx
PREVIOUS MONTH	xxxx	xxxx	xxxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx	xxx

Managed Care TPL Report

Name of Report
Managed Care TPL Report

Frequency
Quarterly

Report Distribution
Managed Care Director-OMPP

Report Definition as of August 14, 2000
This quarterly report gives a count per aid category of the number of enrolled managed care members by program (PCCM and RBMC) for the months in the quarter reporting; the number of enrolled members per aid category who have other insurance (third party liability insurance) for the months in the quarter reporting; and the percentage of enrolled members per aid category who have other insurance for the months reporting. This report totals the number of enrolled members for the months reporting; the number of enrolled members who have other insurance for the months reporting; and the total percentage of enrolled members who have other insurance for the months reporting; and a worksheet is added to reflect gains/losses from previous months reporting.

Queries	Current Purpose
Query 01	Gives a count per aid category of enrolled members in the RBMC Network who have third party insurance
Query 02	Count per aid category of enrolled members in the RBMC network
Query 03	Count per aid category of enrolled members in the PCCM network who have third party insurance
Query 04	Count per aid category of enrolled members in the PCCM network

Distribution List

Name	Organization	Method
Jeanne Lewer	EDS	E-mail
Managed Care Director	OMPP	E-mail
Tammy Robinson	OMPP	E-mail
Sherisse Webb	OMPP	E-mail

Quality Measures

The quality specialist looks at data from six months prior to see if a significant gain\loss is noted. A comparison of all reports that reflect monthly enrollment numbers will be made. Enrollment numbers from this report are logged with enrollment numbers from other reports. The purpose is to compare the numbers fluctuation from timing of the other reports. This also helps visually to see if numbers are accurate or further research of the data is needed. The quality reviewer, after the report is completed, reviews the data for these quality elements:

1. Verification of formulas and totals of report
2. Comparison of data from previous months
3. Formatting errors
4. Typos and spelling errors

Hoosier Healthwise
Managed Care
Package A, B, and C
*****TPL Statistics (Health Insurance)*****

Jul-00	Health Program	Aid Category	# Eligibles with TPL	Total Eligible Population	% Total Eligible Population with TPL	Jul-00	Health Program	Aid Category	# Eligibles with TPL	Total Eligible Population	% Total Eligible Population with TPL
	RBMC	1	0	13	0.0		**PCCM**	1	0	25	0.0
		2	2.590	19.244	13.5			2	11.144	59.109	18.9
		3	0	1	0.0			3	1	1	100.0
		4	4	443	0.9			4	19	796	2.4
		5	0	0	0.0			5	0	0	0.0
		6	0	0	0.0			6	0	0	0.0
		7	0	0	0.0			7	0	0	0.0
		8	0	0	0.0			8	0	0	0.0
		9	1.342	6.738	19.9			9	6.699	24.150	27.7
		A	0	0	0.0			A	0	0	0.0
		B	0	1	0.0			B	0	0	0.0
		C	2.291	43.942	5.2			C	6.566	89.632	7.3
		D	0	1	0.0			D	0	3	0.0
		E	37	291	12.7			E	272	1.244	21.9
		F	618	7.078	8.7			F	2.147	17.536	12.2
		G	0	0	0.0			G	0	0	0.0
		H	0	12	0.0			H	2	34	5.9
		I	0	0	0.0			I	0	0	0.0
		J	0	0	0.0			J	0	0	0.0
		K	0	0	0.0			K	0	0	0.0
		L	0	0	0.0			L	0	0	0.0
		M	34	556	6.1			M	190	2.087	9.1
		N	145	1.099	13.2			N	851	4.707	18.1
		O	0	0	0.0			O	0	0	0.0
		P	0	0	0.0			P	0	0	0.0
		O	0	0	0.0			O	0	0	0.0
		R	0	0	0.0			R	0	0	0.0
		S	1	22	4.5			S	4	29	13.8
		T	67	3.520	1.9			T	150	1.687	8.9
		U	111	3.520	3.2			U	414	8.654	4.8
		V	0	0	0.0			V	0	0	0.0
		W	0	0	0.0			W	0	0	0.0
		X	160	7.717	2.1			X	1.006	20.957	4.8
		Y	55	535	10.3			Y	277	1.550	17.9
		Z	1.309	12.423	10.5			Z	7.041	42.711	16.5
		10	27	525	5.1			10	93	2.152	4.3
	Total		8.791	107.681	8.2		**Total**		36.876	277.064	13.3

Figure 12.2 – Example of Managed Care TPL Reports (part 1 of 2)

Hoosier Healthwise
Managed Care
Package A, B, and C
*****TPL Statistics (Health Insurance)*****
*****Summary July Vs. June*****

Jul-00	Health Program	Aid Category	Gain/Loss of Members with TPL	Gain/Loss of Members in RBMC	Gain/Loss % Total Eligible Population with	Jul-00	Health Program	Aid Category	Gain/Loss of Members with TPL	Gain/Loss of Members in PCCM Program	Gain/Loss % Total Eligible Population with
	RBMC	1	0	0	0.0		**PCCM**	1	0	0	0.0
		2	-91	-650	0.0			2	336	1,676	0.0
		3	0	1	0.0			3	-1	-1	0.0
		4	-1	-32	-0.1			4	-1	17	-0.2
		5	0	0	0.0			5	0	0	0.0
		6	0	0	0.0			6	0	0	0.0
		7	0	0	0.0			7	0	0	0.0
		8	0	0	0.0			8	0	0	0.0
		9	-152	-266	-1.4			9	400	1,237	0.2
		A	0	0	0.0			A	0	0	0.0
		B	0	1	0.0			B	0	0	0.0
		C	-30	178	-0.1			C	256	2,977	0.0
		D	0	0	0.0			D	0	3	0.0
		E	-4	4	-1.6			E	28	86	0.8
		F	-50	-441	-0.2			F	-27	-427	0.1
		G	0	0	0.0			G	0	0	0.0
		H	0	0	0.0			H	0	-1	0.2
		I	0	0	0.0			I	0	0	0.0
		J	0	0	0.0			J	0	0	0.0
		K	0	0	0.0			K	0	0	0.0
		L	0	0	0.0			L	0	0	0.0
		M	7	18	1.1			M	13	49	0.4
		N	13	-28	1.5			N	11	88	-0.1
		O	0	0	0.0			O	0	0	0.0
		P	0	0	0.0			P	0	0	0.0
		O	0	0	0.0			O	0	0	0.0
		R	0	0	0.0			R	0	0	0.0
		S	0	-2	0.4			S	0	1	-0.5
		T	0	2,612	-5.5			T	0	4	0.0
		U	3	-39	0.1			U	11	123	0.1
		V	0	0	0.0			V	0	0	0.0
		W	0	0	0.0			W	0	0	0.0
		X	-11	-222	-0.1			X	16	337	0.0
		Y	-1	-22	0.2			Y	12	11	0.7
		Z	-150	-633	-0.6			Z	261	1,338	0.1
		10	5	104	-0.1			10	21	391	0.2
	Total		-462	583	-0.5		**Total**		1,336	7,909	0.1

Figure 12.2 – Example of Managed Care TPL Reports (part 2 of 2)

Newborn Preselect Report

Name of Report
Newborn Preselect Report

Frequency
Monthly

Report Definition as of August 14, 2000
This monthly report contains all pending newborn PMP preselections made by expectant mothers enrolled in PCCM and RBMC who want to select a PMP for their unborn child. The purpose is to give the enrollment broker and the MCOs advance notice of potentially new members; it can be used for outreach. The reports are categorized by enrollment broker, MCO, and state MCO region. The report is reviewed for duplicate entries. The duplicates are identified, removed, and placed on a duplication report given to the enrollment broker for review. Each MCO gets a distinct report just for their members.

Queries	**Current Purpose**
Query 01	Identifies pending newborn preselection for MaxiHealth by region
Query 02	Identifies pending newborn preselection for MHS by region
Query 03	Identifies pending newborn preselection for PCCM by region

Distribution List

Name	**Organization**
Jeanne Lewer	EDS
Managed Care Director	OMPP
Angela Holloway	MaxiHealth
Angie Stephens	MHS
Lynn Irelan	Lifemark

Quality Measures

The quality specialist looks at data from six months prior to see if a significant gain/loss is noted. Data is checked for duplicate entries. Data is researched in Indiana*AIM* for accuracy. The quality reviewer, after the report is completed, reviews the data for these quality elements:

1. Verification of formulas and totals of report
2. Comparison of data from previous months
3. Formatting errors
4. Typos and spelling errors.

Hoosier Healthwise Newborn Preselect Report
PCCM
As of August 14, 2000

MCO	MCO Region	Provider Number	Group Provider	PMP Indicator	Mother's ID Number	Mother's Last Name	Mother's First Name	Mid Init.

Hoosier Healthwise Newborn Preselect Report
Duplicate Entries
As of August 14, 2000

MCO	MCO Region	Provider Number	Group Provider	PMP Indicator	Mother's ID Number	Mother's Last Name	Mother's First Name	Mid Init.

Hoosier Healthwise Newborn Preselect Report
MaxiHealth
As of August 14, 2000

MCO	MCO Region	Provider Number	Group Provider	PMP Indicator	Mother's ID Number	Mother's Last Name	Mother's First Name	Mid Init.

Hoosier Healthwise Newborn Preselect Report
MHS
As of August 14, 2000

MCO	MCO Region	Provider Number	Group Provider	PMP Indicator	Mother's ID Number	Mother's Last Name	Mother's First Name	Mid Init.

Figure 12.3 – Examples of Newborn Preselect Reports

Eligible vs. Enrolled Report (Package C)

Name of Report
Eligible vs. Enrolled Report (Package C)

Frequency
Monthly

Report Definition as of August 14, 2000

1. This monthly report identifies the number of members in Package C of the Hoosier Healthwise Program. The aid category is 10. The count includes members who fall in the above aid category (Column 2) who may or may not be eligible for Hoosier Healthwise.
2. This monthly report reflects a count by county of **net** eligible members (Column 4) with the above aid categories who are 19 (within that month) and younger. This net eligible count excludes members (Column 3) of the above aid categories with the following factors:
   a) Members with a current Medicare segment
   b) Members 19 (one month after month reporting) and older
   c) Members with a current level-of-care segment
   d) Members who are identified as illegal aliens
   e) Members whose state address is not Indiana
3. The enrolled members (Column 5) are members who have a current PMP assignment.

   Note: This count could include members who, subsequent to their PMP linkage had an eligibility status change and who now need to be disenrolled. These members would appear on the 15th of the Month reports.

4. Column 6 shows a count by county of future assigned members.
5. Column 7 shows a count by county of mandatory enrolled members..
6. Column 8 shows the percentage of mandatory enrolled members by county. The formula is Hoosier Healthwise Mandatory Enrolled Package C Members/Hoosier Healthwise Eligible Package C Members X 100. This is the percentage by county. This data is displayed in column 6 of the current report.

(Continued)

Report Definition as of August 14, 2000

7. Column 9 shows a count by county of the voluntary enrolled members. Voluntary enrolled members are Package C members whose ward indicator reflects the following:
   a) Yes
   b) Ward indicator for Chins
   c) Court order
   d) Parent termination
8. This monthly report identifies the number of eligible members on the potential table 30 days or less by county. This data is shown in column 10 of the current report. Excluded from this count are potential who are the following: B—Self-selecting potential members; for example, wards whose potential members' ward indicator shows the following:
   a) Yes
   b) Ward indicator for Chins
   c) Court order
   d) Parent termination
9. This monthly report also identifies the number of eligible members on the potential table over 30 days by county. This data is shown in column 11 of the current report. Excluded from this count are potential members who are the following:
   a) Package A and B potential members
   b) B—Self-selecting potential members whose potential members' ward indicator shows the following:
      1. Yes
      2. Ward indicator for Chins
      3. Court order
      4. Parent termination
10. Column 12 identifies by county the number of potential members who may self-select (reason code of B) and have been placed on the potential table 30 days and under. These potential members are as follows: B—Self-selecting potential members whose potential members' ward indicator shows the following:
    a) Yes
    b) Ward indicator for Chins
    c) Court order
    d) Parent termination
11. Column 13 identifies by county the number of voluntary potential members who may self-select (reason code of B) and have been placed on the potential table over 30 days. These potential members are as follows: B—Self-selecting potential members; for example, MA3 and MA4)

(Continued)

Report Definition as of August 14, 2000
12. Column 2-10 has statewide totals. Please note column 8 has a statewide percentage of Hoosier Healthwise Enrolled Members/Hoosier Healthwise Eligible Members X 100. This percentage is reflected at the end of column 8 in the current report.
13. Each column has a row at the end of the report to show the total previous month's data for that column.
14. Each column has a row at the end of the report to show the gain/loss of the current month reporting from the previous month.

Aid Categories Legend

Aid Category	Description
1	Children age < 19 who meet TANF income stds
2	Children ages 6-19 under 100% FPL
3	Wards not IVE eligible under 18
4	Title IVE foster children under 18
9	Children age 1-19 up to 150% poverty (CHIP I)
C	Low Income Families
E	Extended Eligibility for Pregnant Women
F	Transitional Medical Assistance
H	Ineligible for AFDC due to deemed income
M	Pregnancy - Full Coverage
N	Pregnancy - Related Coverage
S	Ineligible for AFDC due to sibling income
T	Children age18,19,20 living w/specified relative
U	Ineligible for TANF due to SSI payments
X	Newborn - infants born to Medicaid recipients
Y	Children age<1 under 150% FPL
Z	Children ages 1-5 under 133% FPL

Potential Table Reason Codes

Reason Code	Description
P	Package C
B	Pending for manual assignment (*designated for MA3 and MA4)
C	BA assistance required (assigned when system cannot make an auto-assignment)

Quality Measures

The quality specialist looks at data from six months prior to see if a significant gain is noted for eligible members on the potential table greater than 30 days. If a gain is noted, report is created reviewing the top six counties. Detail analysis is done reviewing the potential members aid categories, age of potential member, sex of potential member, and PMPs availability in county. The data is reviewed in Indiana*AIM*. The quality reviewer, after the report is completed, reviews the data for these quality elements:

1. Verification of formulas and totals of report
2. Comparison of data from previous months
3. Formatting errors
4. Typos and spelling errors

Distribution List

Name	Organization	Method
Jeanne Lewer	EDS	Hard Copy
Managed Care Director	OMPP	E-mail or Courier
Lynn Irelan	MCS	E-mail

Columns in Current Report

County (column 1)	Members with the Package A & B Aid Categories (column 2)	Ineligible Members (column 3)	HH Package A & B Eligible Members (column 4)	HH Package A & B Enrolled Members (column 5)	Pending Enrolled Members (Future Assignment Dates) (column 6)	Mandatory Enrollment (column 7)	HH Percentage Mandatory Enrollment (column 8)	Voluntary Enrollment (column 9)	Eligible Members on Potential Table (Mandatory Enrollment)		Self Selected Eligible Members on Potential Table (Voluntary Enrollment)	
									30 DAYS OR LESS (column 10)	OVER 30- DAYS (column 11)	30 DAYS OR LESS (column 12)	OVER 30-DAYS (column 13)
STATEWIDE TOTALS	XXX	XXX	XXXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
CHANGE FROM PRIOR MONTH	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX
PREVIOUS MONTH	XXXX	XXXX	XXXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX	XXX

PMP Enrollment Report

Name of Report
PMP Enrollment

Frequency
Monthly

Report Definition as of August 14, 2000
This monthly report identifies by county, Network (MCO and PCCM), and PMP Specialty type; FP (Family Practice), FP/O (Family Practice with obstetrics), GP (General Practitioner), GP/O (General Practitioner with obstetrics), IM (Internal Medicine), OB/GYN (Obstetrician and Gynecologist), and Ped (Pediatrician) the number of active Group and Solo Hoosier Healthwise PMPs with active Managed Care Service Location(s). A summary sheet reflects the following information: a monthly statewide gain/loss, monthly net gain/loss broken out by network, a monthly net gain/loss by region, number of counties with net gains, and number of counties with net losses. Also provided is a separate worksheet that shows monthly gains/losses by county.

Queries	Current Purpose
Query 01	Identifies solo Hoosier Healthwise PMPs with active managed care service location(s)
Query 02	Identifies group Hoosier Healthwise PMPs with active managed care service location(s)
Query 03	Confirms potential group PMPs identified in Query 2 that have a current group membership, adding the results in a temporary table that contains the solo PMPs identified in Query 1
Query 04	Identifies solo or group PCCM PMPs
Query 05	Identifies solo or group RBMC PMPs

Distribution List

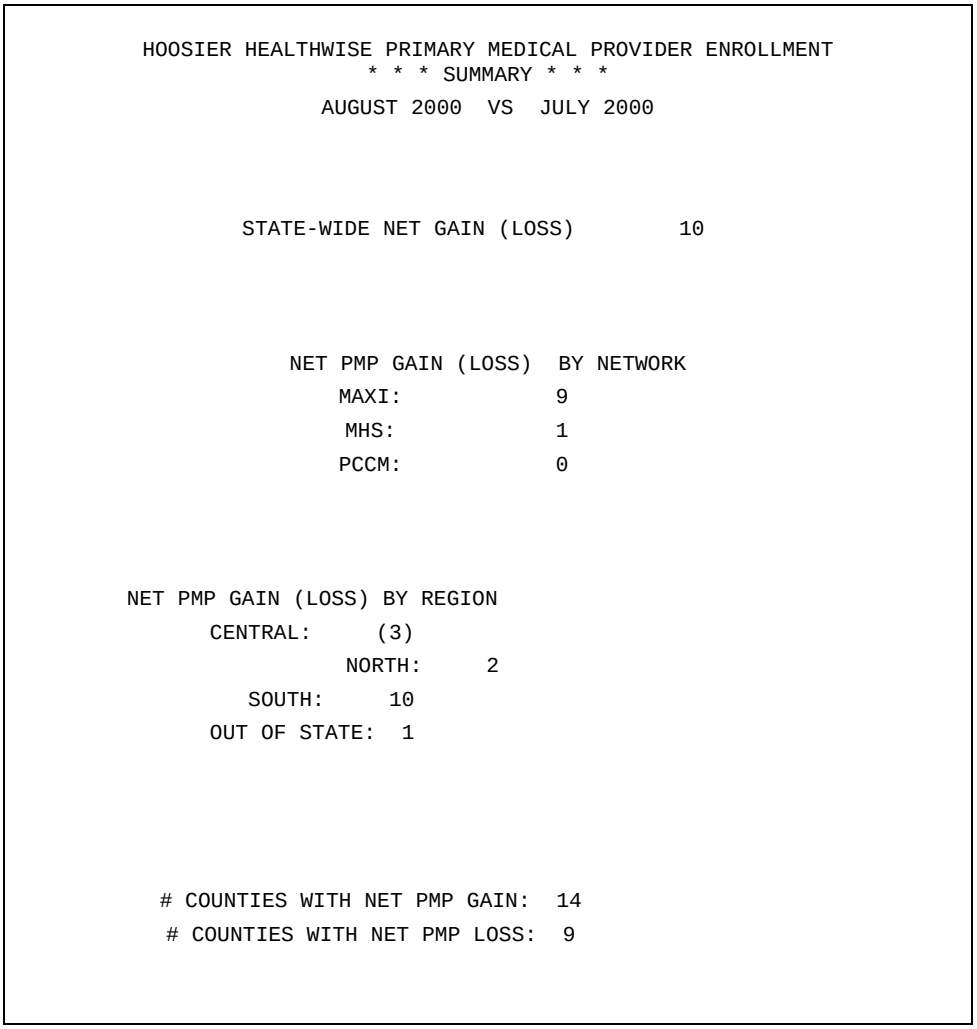
Name	Organization	Method
Martha Whiteman	EDS	Hard Copy
Managed Care director	OMPP	Courier
Jonathan Wolf	OMPP	E-mail
Managed Care staff	EDS	E-mail
Angela Holloway	MaxiHealth	E-mail
Cindy Tays	MHS	E-mail
Lynn Irelan	MCS	E-mail

Query documentation location: *l:\managedcare\Managed Care Unitnit\reports\documentation*.

Quality Measures

The quality specialist looks at data from six months prior to see if a significant gain/loss is noted. If there is a significant gain/loss to a specific region or county, a detailed query identifying the PMP of that county is run. The data is reviewed in Indiana*AIM*. The quality reviewer, after the report is completed, reviews the data for these quality elements:

1. Verification of formulas and totals of report
2. Comparison of data from previous months
3. Formatting errors
4. Typos and spelling errors



HOOSIER HEALTHWISE PRIMARY MEDICAL PROVIDER ENROLLMENT
* * * SUMMARY * * *
AUGUST 2000 VS JULY 2000

STATE-WIDE NET GAIN (LOSS) 10

NET PMP GAIN (LOSS) BY NETWORK
MAXI: 9
MHS: 1
PCCM: 0

NET PMP GAIN (LOSS) BY REGION
CENTRAL: (3)
NORTH: 2
SOUTH: 10
OUT OF STATE: 1

COUNTIES WITH NET PMP GAIN: 14
COUNTIES WITH NET PMP LOSS: 9

Figure 12.4 – Examples of PMP Enrollment Reports (part 1 of 7)

* * * HOOSIER HEALTHWISE PRIMARY MEDICAL PROVIDER ENROLLMENT * * *
AS OF AUGUST 1, 2000
BY COUNTY, DELIVERY SYSTEM AND PROVIDER SPECIALTY

COUNTY		MAXIHEALTH								MHS							PCCM								COUNTY TOTAL
NAME	RGN	FP	FP/O	GP	GP/O	IM	OB/G	PED	TOTAL	FP	FP/O	GP	IM	OB/G	PED	TOTAL	FP	FP/O	GP	GP/O	IM	OB/G	PED	TOTAL	
ADAMS	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
ALLEN	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
BARTHOLOMEW	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
BENTON	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
BLACKFORD	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
BOONE	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
BROWN	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
CARROLL	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
CASS	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
CLARK	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
CLAY	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
CLINTON	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
CRAWFORD	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
DAVIESS	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
DEARBORN	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
DECATUR	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
DEKALB	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
DELAWARE	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
DUBOIS	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
ELKHART	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
FAYETTE	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
FLOYD	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
FOUNTAIN	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
FRANKLIN	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
FULTON	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
GIBSON	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
GRANT	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
GREENE	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
HAMILTON	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

Figure 12.4 – Examples of PMP Enrollment Reports (part 2 of 7)

* * * HOOSIER HEALTHWISE PRIMARY MEDICAL PROVIDER ENROLLMENT * * *
AS OF AUGUST 1, 2000
BY COUNTY, DELIVERY SYSTEM AND PROVIDER SPECIALTY

COUNTY		MAXIHEALTH								MHS							PCCM								COUNTY TOTAL
NAME	RGN	FP	FP/O	GP	GP/O	IM	OB/G	PED	TOTAL	FP	FP/O	GP	IM	OB/G	PED	TOTAL	FP	FP/O	GP	GP/O	IM	OB/G	PED	TOTAL	
HARRISON	S	x	x	x	x	x	x	x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	x
HENDRICKS	C	x	x	x	x	x	x	x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	x
HENRY	C	x	x	x	x	x	x	x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	x
HOWARD	C	x	x	x	x	x	x	x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	x
HUNTINGTON	N	x	x	x	x	x	x	x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	x
IFSSA	OS	x	x	x	x	x	x	x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	x
JACKSON	S	x	x	x	x	x	x	x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	x
JASPER	N	x	x	x	x	x	x	x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	x
JAY	C	x	x	x	x	x	x	x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	x
JEFFERSON	S	x	x	x	x	x	x	x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	x
JENNINGS	S	x	x	x	x	x	x	x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	x
JOHNSON	C	x	x	x	x	x	x	x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	x
KNOX	S	x	x	x	x	x	x	x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	x
KOSCIUSKO	N	x	x	x	x	x	x	x	x	x	x	X	x	x	x	x	x	x	x	x	x	x	x	x	x
LAGRANGE	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
LAKE	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
LAPORTE	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
LAWRENCE	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
MADISON	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
MARION	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
MARSHALL	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
MARTIN	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
MIAMI	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
MONROE	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
MONTGOMERY	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
MORGAN	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
NEWTON	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
NOBLE	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
OHIO	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
ORANGE	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
OWEN	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
PARKE	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
PERRY	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
PIKE	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

Figure 12.4 – Examples of PMP Enrollment Reports (part 3 of 7)

* * * HOOSIER HEALTHWISE PRIMARY MEDICAL PROVIDER ENROLLMENT * * *
AS OF AUGUST 1, 2000
BY COUNTY, DELIVERY SYSTEM AND PROVIDER SPECIALTY

COUNTY		MAXIHEALTH								MHS							PCCM								COUNTY TOTAL
PORTER	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
POSEY	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
PULASKI	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
PUTNAM	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
RANDOLPH	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
RIPLEY	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
RUSH	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
SCOTT	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
SHELBY	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
SPENCER	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
ST. JOSEPH	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
STARKE	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
STEUBEN	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
SULLIVAN	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
SWITZERLAND	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
TIPPECANOE	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
TIPTON	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
UNION	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
VANDERBURGH	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
VERMILLION	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
VIGO	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
WABASH	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
WARREN	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
WARRICK	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
WASHINGTON	S	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
WAYNE	C	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
WELLS	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
WHITE	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
WHITLEY	N	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
TOTALS		x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

Figure 12.4 – Examples of PMP Enrollment Reports (part 4 of 7)

Hoosier Healthwise Primary Medical Provider Enrollment
*** Summary by County ***
August 2000 Vs. July 2000

COUNTY NAME	RGN	Gain/Loss	COUNTY NAME	RGN	Gain/Loss
ADAMS	N	x	LAWRENCE	S	x
ALLEN	N	x	MADISON	C	x
BARTHOLOMEW	S	x	MARION	C	x
BENTON	C	x	MARSHALL	N	x
BLACKFORD	C	x	MARTIN	S	x
BOONE	C	x	MIAMI	N	x
BROWN	S	x	MONROE	S	x
CARROLL	C	x	MONTGOMERY	C	x
CASS	N	x	MORGAN	C	x
CLARK	S	x	NEWTON	N	x
CLAY	S	x	NOBLE	N	x
CLINTON	C	x	OHIO	S	x
CRAWFORD	S	x	ORANGE	S	x
DAVIESS	S	x	OWEN	S	x
DEARBORN	S	x	PARKE	C	x
DECATUR	N	x	PERRY	S	x
DEKALB	N	x	PIKE	S	x
DELAWARE	C	x	PORTER	N	x
DUBOIS	S	x	POSEY	S	x
ELKHART	N	x	PULASKI	N	x
FAYETTE	C	x	PUTNAM	C	x
FLOYD	S	x	RANDOLPH	C	x
FOUNTAIN	C	x	RIPLEY	S	x
FRANKLIN	S	x	RUSH	C	x
FULTON	N	x	SCOTT	S	x
GIBSON	S	x	SHELBY	C	x
GRANT	C	x	SPENCER	S	x
GREENE	S	x	ST. JOSEPH	N	x
HAMILTON	C	x	STARKE	N	x
HANCOCK	C	x	STEUBEN	N	x
HARRISON	S	x	SULLIVAN	S	x
HENDRICKS	C	x	SWITZERLAND	S	x
HENRY	C	x	TIPPECANOE	C	x
HOWARD	C	x	TIPTON	C	x
HUNTINGTON	N	x	UNION	C	x
IFSSA	OS	x	VANDERBURGH	S	x
JACKSON	S	x	VERMILLION	C	x
JASPER	N	x	VIGO	S	x
JAY	C	x	WABASH	N	0
JEFFERSON	S	x	WARREN	C	x
JENNINGS	S	x	WARRICK	S	x
JOHNSON	C	x	WASHINGTON	S	x
KNOX	S	x	WAYNE	C	x
KOSCIUSKO	N	x	WELLS	N	x
LAGRANGE	N	x	WHITE	N	x
LAKE	N	x	WHITLEY	N	x
LAPORTE	N	x	TOTAL		x

Figure 12.4 – Examples of PMP Enrollment Reports (part 5 of 7)

QI Data Grid Report

Name of Report
QI Data Grid Report

Frequency
Monthly

Overall Current Report Definition
This monthly data grid report gives the number of PCCM and RBMC members by region for Package A, B, and C; the number of Package A, B, and C member PMP changes processed; and the number of disenrolled Package A, B, and C members by program and region. Also, this grid reflects a count of Hoosier Healthwise PMPs; and all Medicaid enrolled Dentists, Pharmacies, and Transportation providers; the number of openings for Package A, B, and C members/members enrolled; ratio of Package A, B, and C members to PMP by region, the number of PMPs with closed panels; the number of PMPs with hold panels; the number of PMPs disenrolled; and the number of members affected by program and region.

Queries	Current Purpose
Query 01 Phase 1 of 2	Count of Package A and B Hoosier Healthwise members by program and regions for the month reporting
Query 01 Phase 2 of 2	Count of Package C Hoosier Healthwise members by program and regions for the month reporting
Query 02 Phase 1 of 2	Count of member PMP changes process in that month that affect Package A and B members. The reason codes qualified in this report reason codes are 01, and numbers 40 through 69. Refer to legend to see reason code definitions.
Query 02 Phase 2 of 2	Count of member PMP changes processed in that month that affects Package C members. The reason codes qualified in this report reason codes are 01, and numbers 40 through 69. Refer to legend to see reason code definitions.
Query 03 Phase 1 of 2	Count of Package A and B members who have disenrolled for the month reporting by network and region. Managed care reason codes used are 05, 08, 10, 11, 12, and 13. Refer to legend to see reason code definitions.
Query 03 Phase 2 of 2	Count of Package C members who have disenrolled for the month reporting by network and region. Managed care reason codes used are 05, 08, 10, 11, 12, and 13. Refer to legend to see reason code definitions.
Query 04-Phase 1	Count of PMPs for the PCCM program
Query 04-Phase 2	Count of RBMC PMPs by program and regions for the month reporting
Query 05	Current count of all Medicaid enrolled dentist, pharmacy, and transportation providers

(Continued)

Queries	Current Purpose
Query 06-Phase 1	Count of PCCM PMPs with closed panels
Query 06-Phase 2	Number of RBMC PMPs with closed panels
Query 07-Phase 1	Number of PMPs for the PCCM network whose panels are on hold
Query 07-Phase 2	Number of PMPs for the RBMC network whose panels are on hold
Query 08-Phase 1	Number of PMPs for the RBMC and PCCM networks who have been disenrolled. Attribute CDE_DISENR_STATUS is qualified with = D. This will have data to look at all disenrollment status codes equal to D. A temporary table is created called A_QID08_T1. Also contained in this temporary table are Hoosier Healthwise members who are affected by PMPs who have disenrolled.
Query 08-Phase 2	Actual report count of disenrolled PMPs for the PCCM and RBMC networks
Query 08-Phase 3	Identifies Package A and B Hoosier Healthwise members who are affected by PMPs disenrolled from the PCCM and RBMC networks. A temporary table named A_QID_T_AB
Query 08-Phase 4	Actual report count of Package A and B Hoosier Healthwise members are affected by PMPs who have disenrolled from the PCCM and RBMC Networks.
Query 08-Phase 5	Identifies Package C Hoosier Healthwise members affected by PMPs who have disenrolled from the PCCM and RBMC networks. A temporary table named A_QID_T_C
Query 08-Phase 6	Actual report count of Package C Hoosier Healthwise members affected by PMPs who have disenrolled from the PCCM and RBMC networks.
Query 10-Phase 1	Creates a temporary table named A_QID_T1. This table contains the number of available member slots PMPs have open for the PCCM network.
Query 10-Phase 2	Actual report data count of available member slots PMPs have open for the PCCM network.
Query 10-Phase 3	Creates a temporary table named A_QID_T2. This table contains the number of available member slots PMPs have open for the RBMC network.
Query 10-Phase 4	Actual report data count of available member slots PMPs have open for the RBMC network

Table 12.1 – Code Reason Managed Care Assign Legend

CDE_RSN_MC_ASSIGN	Description
01	Approved Change
02	New Eligible
03	6 Month PMP change
04	Newborn auto-assign change
05	Recipient initiated - MCO disenrollment
06	Redetermination
07	Death
08	Disenroll from Hoosier Healthwise
09 .	Expired Managed Care Segment
10	PCCM Voluntary Disenroll
11	RBMC Voluntary Disenroll
12	PCCM Mandatory Disenroll
13	RBMC Mandatory Disenroll
20	Auto assigned – Newborn
21	Auto Assigned - Case Assignment
22	Auto Assigned – Previous PMP
23	Auto Assigned – Default
24	Auto Assigned - PCCM Disenrolled
25	Auto Assigned - RBMC Disenrolled
26	Auto Assigned - Newborn Preselection
27	MCPD – Other
28	Auto Assigned – Redetermination
30	Voluntary county enrollment
31	Aprvd. Chng. - Recipient Choice Auto-assignment
35	Aprvd. Chng. - PMP Panel Full
40	Aprvd. Chng. - PCCM PMP Disenrolled
41	Aprvd. Chng. - RBMC PMP Disenrolled
42	Aprvd. Chng. - Error in Assignment
43	Aprvd. Chng. - MCO Ancillary Service Access Issues
44	Aprvd. Chng. - PCCM Ancillary Service Access Issues
45	Aprvd. Chng. - Quality of Service Issues
46	Aprvd. Chng. - Third Party Liability
50	Aprvd. Chng. - Inconvenient Location

(Continued)

Table 12.1 – Code Reason Managed Care Assign Legend

CDE_RSN_MC_ASSIGN	Description
51	Aprvd. Chng. - Recipient Moved
52	Aprvd. Chng. - Transportation Problems
53	Aprvd. Chng. - Appointment Delays
54	Aprvd. Chng. - Waiting Time
55	Aprvd. Chng. - Treatment by staff
56	Unsatisfactory Communication
57	Aprvd. Chng. - Unsatisfactory quality of care
58	Unsatisfactory emergency response
59	Aprvd. Chng. - Unable to obtain referral
60	Aprvd. Chng. - Insufficient after-hours coverage
61	Aprvd. Chng. - Physician no longer Medicaid
62	Aprvd. Chng. - Physician no longer in practice
63	Aprvd. Chng. - Physician Patient rltnshp unacpt
64	Aprvd. Chng. - Med condition not approp to pvdr
65	Physician requests recip reassign
66	Aprvd. Chng. - Speclty not consistent with cond.
67	Aprvd. Chng. - Preg. related - ante-partum change
68	Aprvd. Chng. - Preg. related - post-partum change
68	Aprvd. Chng. - Preg. related - post-partum change
69	Aprvd. Chng. - Other
70	ICES County Change
71	Residency Change
72	Third Party Liability Issues
73	Continuity of Care Issues
74	Recipient Determined to be Illegal Alien
75	Recipient Choice - Enrolled in HCBS Waiver Program
76	Recipient Choice - Ward or Foster Child
77	Network Limitations
78	More than one RID # linked from ICES
79	Recipient in Hospice
80	Recipient Ineligible Due To Age
81	Eligibility was removed
99	Open

Managed Care Disenrollment Code Legend

CDE_DISENROLL_RSN	DSC_DISENROLL_RSN
PM	MCO Dsnrl - PMP Reenrolls with new MCO
PP	MCO Dsnrl - PMP Reenrolls in PCCM
PA	Voluntary Disenroll
PB	Provider Medicaid Eligibility Terminated
PC	Group Medicaid Eligibility Terminated
PD	PMP Specialty Changed to NonManaged Care
PE	PMP Service Location No Longer Active
PF	PMP Group Enrollment Terminated
PG	Mandatory Disenrollment
PS	MCO Dsnrl PMP does not enrolls in Pgm

CDE_DISENROLL_STATUS	DSC_DISENROLL_STATUS
A	Approved
D	Disenrolled
W	Approval Pending
X	Canceled

Quality Measures

The quality specialist reviews data from six months prior to see if a significant gain\loss is noted. A comparison of all reports that reflect monthly enrollment numbers is made. Enrollment numbers from this report are logged with enrollment numbers from other reports. The purpose is to compare the number fluctuation from timing of the other reports. This also helps to visually see if numbers are accurate or further research of the data is needed. The quality reviewer, after the report is completed, reviews the data for these quality elements:

1. Verification of formulas and totals of report
2. Comparison of data from previous months
3. Formatting errors
4. Typos and spelling errors

HOOSIER HEALTHWISE PROGRAM
QI Data Grid
Package A, B, and C
As of July 31, 2000

	NETWORK / REGION							
	PCCM			MAXIHEALTH			MHS	GRAND
	Central	North	South	Central	North	South	Central	TOTALS
Member Totals								
# Members (Package A and B)	102,958	90,763	81,204	1,830	48,677	6,734	47,503	379,669
# Members (Package C)	789	602	746	11	202	54	249	2,653
# Members (Package A, B, and C)	103,747	91,365	81,950	1,841	48,879	6,788	47,752	382,322
# Members Making PMP Changes (Processed) (Package A and B)	454	344	326	13	573	90	153	1,953
# Members Making PMP Changes (Processed) (Package C)	3	1	1	1	1	1	1	9
# Members Making PMP Changes (Processed) (Package A, B, and C)	457	345	327	14	574	91	154	1,962
# Members Disenrolled (Package A and B)	599	2,757	1,305	6	359	19	3	5,048
# Members Disenrolled (Package C)	3	13	9	0	1	2	0	28
# Members Disenrolled (Package A, B, and C)	602	2,770	1,314	6	360	21	3	5,076
Provider Totals								
# PMPs	582	602	455	12	167	52	151	2,021
# Dentists	694	524	424	0	0	0	0	1,642
# Pharmacies	613	801	348	0	0	0	0	1,762
# Transportation Providers	82	143	65	0	0	0	0	290
Ratio of Members to PMP by Region	178	151.8	180	153.4	292.7	130.5	316.2	189.2
# PMP's with Full Panels	94	64	64	0	19	10	6	257
# PMP's with Hold Panels	8	18	11	0	4	4	0	45
% PMP's with Full/Hold Panels	17.5	13.6	16.5	0	13.8	26.9	4.0	14.9
# of PMP Disenrollments	20	19	12	1	4	1	1	58
# of Members Affected by PMP Disenrollments (Package A and B)	4,233	3072	3217	6	350	17	0	10,895
# of Members Affected by PMP Disenrollments (Package C)	24	13	21	0	1	2	0	61
# of Members Affected by PMP Disenrollments (Package A, B, and C)	4,257	3,085	3,238	6	351	19	0	10,956
Available Panel Slots	215,978	249,384	148,083	18,876	71,379	13,708	128,624	846,032
# Available Panel Slots/Members Enrolled	2	3	2	10	1	2	3	2

Figure 12.5 – Example of a QI Data Grid Report

Shadow Graph Reports

Indiana Title XIX

Managed Care

Documentation of Monthly Shadow Graph Reports

Frequency: Monthly
Name of Report: Shadow Graph Reports

Purpose of the Shadow Graph Reports: These bar graphs reflect by claim type, MCO, and MCO Region, the number of paid and denied claim details in a twelve month date range. Also represented on the graphs, by a line representation, is the enrollment for that MCO Region.

Shadow Graph Report Range Schedule

Report Month	Report Range From	Report Range To
November 1999	September 1998	August 1999
December 1999	October 1998	September 1999
January 2000	November 1998	October 1999
February 2000	December 1998	November 1999
March 2000	January 1999	December 1999
April 2000	February 1999	January 2000
May 2000	March 1999	February 2000
June 2000	April 1999	March 2000
July 2000	May 1999	April 2000
August 2000	June 1999	May 2000
September 2000	July 1999	June 2000
October 2000	August 1999	July 2000
November 2000	September 1999	August 2000
December 2000	October 1999	September 2000

Illustration 1a

Figure 12.6 – Shadow Graph Report Documentation (part 1 of 3)

Claim Data Location for Shadow Graphs
by MCOs, MCOs Region, and Claim Type

Claim Types	MaxiHealth			MHS
	C	**S**	**N**	**C**
Pharmacy	Rows 18-21	Rows 27-30	Rows 22-25	Rows 32-35
UB 92	Rows 37-40	Rows 46-49	Rows 41-44	Rows 51-54
Physicians	Rows 1-4	Rows 9-12	Rows 5-8	Rows 13-16
***Dental**	Rows 51-54	Rows 61-64	Rows 56-59	Rows 66-69

Illustration 1b

*Dental Claim data is no longer reported. Dental Services are carved out of the Risk-Based Managed Care Program effective 08-01-1999.

I. Preparation Steps Prior to creating the Shadow Graph Report

a) **Go to** Excel.
b) **Go to** directory l:\Manage Care\Managed Care Unitnit\Sanction\Shadow99.xls
c) Open document and print.
d) Review data from Shadow 99.xls
e) **Go to** directory l:\Manage Care\Managed Care Unitnit\Sanction\Scgraphs2a.xls
f) Place data from Shadow99.xls onto Scgraphs2a.xls in worksheet tab named **Claim Data for Graphs**.
g) Make sure the data being placed is being placed in the correct cell. Refer to Illustration 1b.
h) Enrollment Data will also be placed into this worksheet. Refer to the documented DSS Enrollment Query for step-by-step instructions of creating the DSS report.

Figure 12.6 – Shadow Graph Report Documentation (part 2 of 3)

II. Creating the Shadow Claims Graphs

a) Review the current month Data Ranges to be created for the reports. (Refer to Illustration 1a)
b) Go to the worksheet named **Pharmacy**.
c) Go to MaxiHealth Central
d) Left click your mouse in the center of the graph. (This will outline area of the data graphs)
e) Hold mouse in the same area and do a right click.
f) Select Source Data
g) Select Source Data-Data Range Box.
h) The worksheet named Claim Data for Graphs will be displayed.
i) Change cell range for the Claim Range that is to be reported. Example: November 1999 Range to Report is September 1998 to August 1999

Maxi Central Before:
= 'Claim Data for Graphs'! $C$25:$C$28, 'Claim Data for Graphs'!$I$25:$U$28

Maxi Central After
(Information to be entered)
='Claim Data for Graphs'! $C$25:$C$28, 'Claim Data for Graphs '!J$25:$V$28

j) Repeat steps for MaxiHealth North, MaxiHealth South, and MHS Central
k) Go to worksheet named **Physicians.**
l) Repeat steps c) through i).
m) Repeat step j)
n) Go to worksheet named UB 92.
o) Repeat steps c) through i).
p) Repeat step j).
q) Go to each claim type report and change the report range to reflect the report range for the current month.

Figure 12.6 – Shadow Graph Report Documentation (part 3 of 3)

Top 10 Shadow Claim Denial Reports

Name of Report
Top 10 Shadow Claim Denial Report

Frequency
Monthly

Overall Current Report Definition
This report shows the Top 10 Shadow Claim Denial reasons for each claim type submitted by MCO and MCO region. Data reported is from the previous month's claim submissions. It is provided to the MCOs at the Monthly Technical Meeting.

Queries	Current Purpose
Query 01	Identifies the number of denied detail claim errors for pharmacy claim types. This data is placed in the temporary table named A_TOP10_R1.
Query 02	Actual data results reported on the Top 10 Shadow Claim Errors for Pharmacy Claim Types
Query 03	Identifies paid physician claims status with denied details. This data is placed in the temporary table named A_TOP10_P1.
Query 04	Identifies denied physician claims status with denied details. This data is sent to temporary table A_TOP10_P1.
Query 05	Actual data results reported on the Top 10 Shadow Claim Errors for Physician Claim Types
Query 06	Identifies paid UB-92 claim status with denied details. This data is placed in the temporary table named A_TOP10_U1.
Query 07	Identifies denied UB92 claim status with denied details. This data is placed in temporary table A_TOP10_U1.
Query 08	Actual data results reported on the Top 10 Shadow Claim Errors for UB92 Claim Types

Distribution List

Name	Organization
Jeanne Lewer	EDS
Managed Care Director	OMPP
Fred Mirmelstein	EDS
Myra Crenshaw	EDS
Cindy Tays	MHS
Lynn Irelan	Lifemark

Reports are distributed to the MCOs and OMPP two days before the Technical Meeting.

Quality Measures

The quality specialist looks at previous data to see if a significant gain/loss is noted. Data is checked for duplicate entries. If the quality specialist or quality reviewer notice an EOB that needs to be reviewed, a detail query can be created and claims reviewed in Indiana*AIM.* The quality reviewer, after the report is completed, reviews the data for these quality elements:

1. Verification of formulas and totals of report
2. Comparison of data from previous months
3. Formatting errors
4. Typos and spelling errors

MHS TOP 10 SHADOW CLAIM DENIAL REASONS
*** * * PHARMACY CLAIMS * * ***
May 2000

CENTRAL REGION

RANK	EOB CODE	SHORT DESCRIPTION (79 Char)	NUMBER OF ERRORS
1	206	THE PRESCRIBING PRACTITIONER'S LICENSE NUMBER SUBMITTED ON THIS CLAIM IS NOT IN	61
2	2022	RECIPIENT NOT ENROLLED WITH BILLING MANAGED CARE ORGANIZATION.	54
3	1026	PRESCRIBING PHYSICIAN LICENSE NUMBER NOT ON FILE. PLEASE VERIFY NUMBER AND RES	46
4	4007	NDC NOT COVERED FOR DATE OF SERVICE.	34
5	3002	NDC REQUIRES PRIOR AUTHORIZATION, NO APPROVED PA ON FILE.	10
6	2002	DISPENSED DATE PRIOR TO INDIANA HEALTH COVERAGE PROGRAMS ELIGIBILITY DATE	9
7	5001	THIS IS A DUPLICATE OF ANOTHER CLAIM.	9
8	1025	BILLING PROVIDER NOT ENROLLED IN THE PROGRAM BILLED.	4
9	2007	QUALIFIED MEDICARE BENEFICIARY (QMB) RECIPIENT-PLEASE BILL MEDICARE FIRST.	2
10	4004	THIS NDC IS NOT ON FILE. PLEASE VERIFY THAT THE NDC WAS FILED CORRECTLY. IF T	2

Figure 12.7 – Example of MHS Top 10 Shadow Claim Denial Reasons Report for Pharmacy Claims

MHS TOP 10 SHADOW CLAIM DENIAL REASONS

*** * * PHYSICIAN CLAIMS * * ***

May 2000

CENTRAL REGION

RANK	EOB CODE	SHORT DESCRIPTION (79 Char)	NUMBER OF ERRORS
1	4035	PROCEDURE CODE BILLED NOT COMPATIBLE WITH RECIPIENT'S SEX. PLEASE VERIFY AND R	5
2	4200	PRICING BEING REVIEWED.	5
3	1028	MODIFIER BILLED NOT PAYABLE FOR THIS PROVIDER'S SPECIALTY. PLEASE VERIFY MODIF	3
4	9600	REIMBURSMENT IS LIMITED TO A MAXIMUM OF ONE (1) PAIR OF LENSES PER YEAR FOR REC	3
5	9651	SURGERIES ON THE SAME DATE OF SERVICE, IN THE EXCESS OF TWO, ARE PAID AT 25 PE	3
6	1007	PROVIDER NUMBER OF THE RENDERING PHYSICIAN IS NOT ON FILE. PLEASE VERIFY PROV	2
7	6604	LENSES INITIAL OR REPLACEMENT-RECIPIENT 19 YEARS OR OLDER	2
8	6659	REIMBURSEMENT REFLECTS THE DIFFERENCE BETWEEN INDIANA HEALTH COVERAGE PROGRAM'S	2
9	507	THE "FROM" DATE IS AFTER THE "TO" DATE OF SERVICE. PLEASE VERIFY AND RESUBMIT.	1
10	1033	PROVIDER DOES NOT HAVE A SPECIALTY AREA IDENTIFIED FOR THE DATES OF SERVICE. P	1

Figure 12.8 – Example of MHS Top 10 Shadow Claim Denial Reasons Report for Physician Claims

MHS TOP 10 SHADOW CLAIM DENIAL REASONS

*** * * UB92 CLAIMS * * ***

May 2000

CENTRAL REGION

RANK	EOB CODE	*TYPE	SHORT DESCRIPTION (79 Char)	NUMBER OF ERRORS
1	4095	O	A NON-SURGICAL SERVICE IS NOT REIMBURSED INDIVIDUALLY IF PERFORMED IN CONJUNCTI	858
2	389	O	THE REVENUE CODE SUBMITTED REQUIRES A CORRESPONDING HCPCS CODE.	544
3	4090	O	PAYMENT FOR 250, 251, 252, 257, 259, 27X DRUG AND SUPPLY REVENUE CODE ARE INCLU	267
4	518	I	THE COVERED DAYS ENTERED DO NOT MATCH THE STATEMENT PERIOD DATES. PLEASE VERIFY	207
5	4107	O	REVENUE CODE IS NOT APPROPRIATE/NOT COVERED FOR THE "TYPE" OF SERVICE BEING PRO	166
6	4105	O	PRICING BEING REVIEWED	82
7	5001	O	THIS IS A DUPLICATE OF ANOTHER CLAIM.	75
8	278	I	THE ADMIT TYPE IS MISSING-PLEASE PROVIDE AND RESUBMIT.	71
9	4207	O	EFFECTIVE CLIA NUMBER NOT ON FILE FOR DATES OF SERVICE BILLED.	58
10	8327	O	BILLING AND/OR RENDERING PROVIDER NUMBER NOT VALID FOR WAIVER SERVICES BILLED.	53

Figure 12.9 – Example of MHS Top 10 Shadow Claim Denial Reasons Report for UB-92 Claims

System-generated Reports

A Managed Care Potential Improvement Log item describing a review of all managed care reports and tapes is pending assignment. Once complete, it may be determined that reports and tapes currently systematically generated may be eliminated. Detailed information about systematically generated reports will be developed in conjunction with this project. The following table lists managed care reports currently stored on CRLD.

Table 12.2 - Managed Care Reports on CRLD

Report Number	Report Name
MGD0001M	PMP Listing by County
MGD0002M	Capitation Payment Listing
MGD0003M	Hoosier Healthwise Admin Fee Payment
MGD0004B	MCO Enrollment Roster
MGD0005B	PMP Enrollment Roster
MGD0006D	Hoosier Healthwise Eligible Listing
MGD0008M	Hoosier Healthwise Primary Medical Providers
MGD0012W	PMP Addendum Waiting Additional Info
MGD0013W	Unassigned HH Eligible 20 > Identification Date
MGD0014D	Certification Code Summary
MGD0014Q	Certification Code Summary Report
MGD0015Q	Certification Code Error Report
MGD0016D	Hoosier Healthwise Recipient Linkage
MGD0023Q	PCCM Enrollee: Characteristics
MGD0024Q	RBMC Enrollee: Characteristics
MGD0025Q	Hoosier Healthwise Enroll
MGD0034B	RBMC PMP Enroll Roster
MGD0040M	Capitation Reconciliation

Appendix A: File/Tape/Report/Letter - Tracking Table

Job Script	Description/ Comments	Frequency Distribution	Who Receives	Delivery Form	How Distributed
MGDJM451	Electronic PMP List	1 x mo / ~22nd	Lifemark	8mm cartridge	Operations takes to EDS front desk
MGDJS101;201	PMP assignt and potential recips	2 x mo / ~11th, 27th	Lifemark	8mm cartridge	**3/20/02 Note: This process will be deleted; Lifemark no longer needs.** Operations takes to EDS front desk (runs 3 tapes and a spare)
MDS0080X	MCO Tape Extract of Medicaid Prvdrs	1 x mo / ~12th	MCOs	Tape only	One each for MDwise and MHS – left at front desk, and Harmony – mailed
MGDJS300	TPL	1 x mo / ~27th	MCOs	BBS and tape	BBS: posted by system, retrieved by MCO
MGDJS410	Enrollment Rosters	2 x mo / ~11th, 27th	MCOs	BBS and tape	BBS: posted by system, retrieved by MCO retrieve their file from the BBS.
MGDJM100	Capitation Reports	1 x mo / Thurs following the first Wed on or after the 15th	MCOs	BBS and tape	BBS: posted by system, retrieved by MCO Tape: OPS brings to Managed Care Unit who holds for approx 5 days in case the MCO is unable to retrieve their file from the BBS.
MGDJM000	PCCM Admin Fees	1 x mo / check/RA after the first Wed and financial week on or after the 15th	PCCM PMPs	Payment	
MGDJM440	PCCM Admin Fee Report to PMPs	1 x mo / Thurs following the first Wed on or after the 15th	PCCM PMPs	Paper	

Job Script	Description/ Comments	Frequency Distribution	Who Receives	Delivery Form	How Distributed
MGDJS400	PCCM PMP Enrollment Roster	2 x mo / ~11th, 27th	PCCM PMPs	Paper	
MGDJS430	RBMC PMP Enrollment Roster	2 x mo / ~11th, 27th	RBMC PMPs	Paper	
MGDJQ100	Cert Code Letters – regular release	Quarterly / ~20th prior to the start of ea quarter	PCCM PMPs	Paper	
MGDJD300	**Cert Code Letters–for newly enrolled**	Daily or as needed	PCCM PMPs	Paper	
MGDJD200	HH Welcome Letters*	Daily or as needed	Managed Care Members	Paper	
MGDJD53X	Various Disenrollment Letters*	Daily or as needed	Members/PMPs/MCOs	Paper	
FN103011	EFT Notices**	1 x mo / week following the first Wed on or after the 15th	MCOs	Paper	Mailed to MCOs address (found on MCO Maintenance Window in AIM)
FN103011	MCO Cap RAs**	1 x mo / week following the first Wed on or after the 15th	MCOs	Paper	Mailed to MCOs address (found on MCO Maintenance Window in AIM)

Appendix B: Managed Care Policy Meeting Agenda Item Request Form

MANAGED CARE POLICY MEETING AGENDA ITEM REQUEST

DATE:

PRESENTED BY:

SUMMARY/EXPLANATION OF AGENDA ITEM:

SUPPORTING DOCUMENTATION:
(State specific examples and rate of occurrence.)

IDENTIFY PROGRAM IMPACT/SYSTEMS IMPACT:
(Please state if unknown.)

DESIRED OUTCOME OR SUGGESTED RESOLUTION:

Figure B.1 – Managed Care Policy Meeting Agenda Item Request Form

Appendix C: Certification Code Tracking Referral Form

Instructions for Tracking/Referral Slip

1. Verify request is from the PMP's service location office. For additional information on researching PMP service locations, see the Instructions for Researching Cert Code Requests. (*I:\Cert Codes\Research Instructions.doc*)
2. Verify correct provider address for PMP service location listed in Indiana*AIM*.
3. If address is incorrect in the system, have providers contact their enrollment broker (Lifemark for PCCM or the MCO for RBMC) to update their enrollment records (requests for address changes must be made in writing).
4. Once address is verified, complete the tracking referral slip below and submit the certification code request to the Managed Care Unit on the same day the request was made.
5. Place the referral slip in the Managed Care Unit inbox folder named **Cert Code Requests**.

For PCCM/PMP Providers Requesting Certification Codes

Date_____

PMP Provider Name_____

Provider Number_____ Group Number_____

Provider Telephone Number_____

Fax#_____

Name of Caller_____

Brief Description of Issue_____

_____

Is the address Correct in AIM? Please verify

Yes No

EDS Analyst Name:_____

Figure C.1 – Tracking Referral Slip

Appendix D: Certification Code Recovery Letter

Date

Name
Address
City, State, ZIP
Fax #

Dear Hoosier Healthwise Provider:

We understand that you did not receive your quarterly certification code letter in a timely manner and apologize for the inconvenience this has caused you or your office staff. The certification code letter is a tri-fold, one-piece letter with the address printed on the outside and the certification code information printed on the inside. Additionally, letters are mailed the first week of the month prior to the new quarter certification codes are generated.

Certification code letters are always mailed to the service location where the PMP is assigned (which is currently the address listed above). If you are a PMP in a group, then the certification code letters are mailed to the address on file for your group's PMP service location. If the above address is not what you submitted on your PMP enrollment addendum for your PMP service location, please contact your enrollment broker (Prime*Step* PMPs should contact Lifemark and MCO PMPs should contact their contracting MCO) to update your PMP service location information. Address changes to your Indiana Health Coverage Programs (IHCP) enrollment must be submitted on the address update forms available on the Indiana Medicaid web site, or by requesting copies from EDS Customer Assistance at 317-655-3240 or 800-577-1278.

Please find below your current quarterly certification code. Provide this code along with your Indiana Health Coverage Programs (IHCP) provider or Indiana medical license number, to any other IHCP provider to whom you have referred one of your Hoosier Healthwise Prime*Step* (PCCM) members. The following is the certification code information you requested:

(enter code**)** effective from (enter date)

Sincerely,
The Managed Care Unit

Figure D.1 – Recovery Letter

Appendix E: Information for Researching Certification Code Issues

- Certification codes are only given to PCCM PMPs, not MCO PMPs.
- Certification codes are only provided to the service location where the PCCM PMP is assigned, all others, including ancillary providers, requesting certification codes need to be referred to the member's PMP.
- Certification codes are assigned to PMPs quarterly (1st Quarter: January – March; 2nd Quarter: April – June; 3rd Quarter: July – September; 4th Quarter: October – December).
- Certification code letters are system generated. The letters are printed the second week of the last month of the quarter and mailed within three days of printing.
- Certification codes are two characters, which can be either an alphabetic character or a numerical character, or any combination of the two.
- It is possible for two providers to have the same certification code. The security is in the PMP ID# and Certification Code combination.

Research and resolution steps:

1. Verify correct provider address for PMP service location listed in Indiana*AIM*. Certification code letters are mailed to the service location of individual PMP providers. If the provider is a PMP in a group, the letter is mailed to the service location of the group with which the PMP is assigned as a PMP.
2. To determine if the provider is a PMP under a group or a PMP under an individual location, go to the Provider Base screen, open the PMP window and view all locations. If there is a group provider number listed with the individual provider number, the PMP is under a group. The group provider number's service location is where the cert code letters are sent; please verify the group's service location address. If there is no group listed, the cert code letters will go to the service location listed for the individual provider number.
3. If the PMP button is not highlighted (or no valid information is listed) on the base screen, select **Group Info** and using the PMP Service button go through each location to see old locations where the provider was enrolled as a PMP.

4. If the Group Info button is not highlighted go to the service location window and from the options scroll down to the PMP Serv Loc and check for old PMP individual locations. Do this for each service location listed on the provider's base screen.
5. Certification codes are not to be given out over the telephone, a Tracking/Referral slip must be completed and submitted to the Managed Care Unit the same day a request is received. Tracking/Referral slips are placed in the Managed Care Unit's inbox folder named **Cert Code Requests**.
6. Every effort is made to complete requests for certification codes within 24 hours of receipt. However, if the requester insists on immediate action, hand deliver the request to the Managed Care Unit specialist responsible for completing requests for certification codes.
7. Submit the appropriate paperwork to the EDS Provider Enrollment Unit to have the information updated in Indiana*AIM*.

Appendix F: Project Task Plan Mask

Project Task Plan			
Project Summary Information			
Control No			
Date Opened			
Task Name			
Task Leader			
Members			
Purpose			
Scope			
Training or Skills			
Measurement			
Project Milestones			
Sub-Task Description		**SCHEDULED DUE DATE**	**Actual Date Delivered**
Project Status			
STATUS:			
Issues:			

Figure F.1 – Project Task Plan Mask

Appendix G: Internal Provider Accounts Receivable Form

INTERNAL PROVIDER ACCOUNTS RECEIVABLE

Submitted by: _____ Date: _____

Provider Number: _____ Name: _____

SETUP REQUEST

Effective Date: _____ Interest Accrual Date: _____

Program Code (circle one) Medicaid 590 ARCH CSHCS

Reason for Setup (indicate Risk or Non risk and prior/after 7/1/94): _____

Setup Amount: _____ RID No.: _____

Recoupment Amount: _____ Recoupment %.: _____

DISPOSITION/UPDATE REQUEST

Effective Date: _____ Interest Accrual Date: _____

Disposition Amount: _____ ***Increase*** ***Decrease***

Recoupment Amount: _____ Recoupment %.: _____

To be filled out by AR clerk

Date Entered: _____

AR Number Assigned: _____

Reason Code Assigned: _____

Figure G.1 – Internal Provider Accounts Receivable Form

Glossary

Balanced Budget Act of 1997	Public Law 105-33 that makes numerous changes to various titles of the Social Security Act and creates a new Title XXI, the State Children's Health Insurance Program (CHIP).
Capitation rate	A set of fixed fees that the OMPP pays monthly to an eligible managed care organization for each enrolled Hoosier Healthwise member for the provision of covered medical and health services whether the enrollee received services during the month for which the fee is intended. These rates vary by eligibility category.
Central Region	A Hoosier Healthwise enrollment area in Central Indiana that includes the following counties: Benton, Blackford, Boone, Carroll, Clinton, Delaware, Fayette, Fountain, Grant, Hamilton, Hancock, Hendricks, Henry, Howard, Jay, Johnson, Madison, Marion, Montgomery, Morgan, Parke, Putnam, Randolph, Rush, Shelby, Tippecanoe, Tipton, Union, Vermillion, Warren, and Wayne.
Children's Health Insurance Program (CHIP)	A part of the Balanced Budget Act of 1997 that includes an expansion of the Medicaid program that extends coverage to children ages zero to 19 years old whose family income is the federal poverty level.
Clinical Advisory Committee (CAC)	The committee established by the OMPP comprised of actively participating medical providers enrolled in Hoosier Healthwise. The CAC's mission is to advise the OMPP concerning its policies by making recommendations that support the quality, accessibility, appropriateness, and cost-effectiveness of health and medical care provided to Hoosier Healthwise members.
Early Periodic Screening, Diagnosis, and Treatment (EPSDT)/ HealthWatch Services	Those services described at 405 IAC 5-15 as required by Federal law pursuant to 42 U.S.C. 1396d, which include certain preventive services to children under 21 years of age with emphasis given to early detection and prevention of conditions that may result in more costly treatment or long term effects.
Emergency Medical Condition	A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
Emergency Services	With respect to an individual enrolled with a managed care organization, covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition.
EQRO	External Quality Review Organization
FQHC	Federally Qualified Health Center—A publicly funded health care network established under the Omnibus Budget Reconciliation Act (OBRA) of 1989 to increase access to medical care for the homeless, the underinsured and uninsured

HCFA	Health Care Financing Administration—The federal government agency responsible for the IHCP (Medicaid)
Health Insurance	Includes, but is not limited to, coverage by any health care insurer, Health Maintenance Organization, or an employer-administered ERISA plan.
Home and Community Based Services (HCBS) Waiver Program	Eligible participants in HCBS Waiver programs are eligible for IHCP and receive home or community based services not otherwise reimbursed by the Program.. Participants in an HCBW program would require institutionalization in the absence of the waiver services. Additional information about waiver services may be found in the *IHCP Provider Manual*.
Hoosier Healthwise	The managed care component of the Indiana Health Coverage Programs for the TANF, Pregnancy Medicaid, and Children's Medicaid populations in which medical care is available in primary care case management (Prime*Step*) or risk-based managed care (MCO) networks.
Hoosier Healthwise for Persons with Disabilities (HHPD)	A voluntary risk-based managed care program for the IHCP enrollees who are considered disabled or chronically ill according to the state's established criteria. This pilot program, available in Marion County from January 1997, through December 1999 has been discontinued, but may be reinstated at a later time.
ICES	Indiana Client Eligibility System. Caseworkers in the county offices of the Division of Family and Children use this system to help determine applicants' eligibility for medical assistance, food stamps, and Temporary Assistance for Needy Families (TANF).
IHCP	Indiana Health Coverage Programs.
Indiana*AIM*	The Indiana Advanced Information Management System; another name for the State's Medicaid Management Information System (MMIS).
Indiana Family and Social Services Administration (IFSSA)	The umbrella agency responsible for administering many of Indiana's social services programs, including those administered by the Office of Medicaid Policy and Planning and the Office of the Children's Health Insurance Program
MCO	Managed Care Organization.
Managed Care Unit	Managed Care Unit.
Managed Care Organization Enrollee or Member	An IHCP or CHIP enrollee participating in Hoosier Healthwise and enrolled in one of the Hoosier Healthwise managed care organizations.
Managed Care for Persons with Disabilities (MCPD)	See Hoosier Healthwise for Persons with Disabilities
Medicaid or Medical Assistance Program	Medicaid is a federal-state mandated medical assistance program administered by the State to provide reasonable and necessary medical care for persons meeting medical and financial eligibility requirements pursuant to federal law, *42 U.S.C. 1396* and state law, *IC 12-15*. The Medicaid program in Indiana is known as Indiana Health Coverage Programs (IHCP).

Medicaid covered service	A service provided or authorized by an IHCP provider for an IHCP enrollee for which payment is available under the IHCP as set forth in *405 IAC 5*. A list of covered services is referenced in *IC 12-15-5-1*.
Medicaid Management Information System (MMIS)	The IHCP payment and information system of the Indiana Family and Social Services Administration; also known as Indiana*AIM*.
Medicaid Recipient/Indiana Health Coverage Programs Enrollee	An IHCP enrollee in one of these aid categories: Aged; Blind and Disabled; Temporary Assistance for Needy Families; Pregnancy Medicaid; Children's Medicaid.
Medically Necessary	Medically necessary services covered by the IHCP are specified in *405 IAC 5*.
Member or Enrollee	An IHCP recipient who is enrolled in any of the state's health coverage programs.
Northern Region	A Hoosier Healthwise enrollment area in Northern Indiana that includes the following counties: Adams, Allen, Cass, Dekalb, Elkhart, Fulton, Huntington, Jasper, Kosciosko, LaGrange, LaPorte, Marshall, Miami, Newton, Noble, Porter, Pulaski, St. Joseph, Starke, Steuben, Wabash, Wells, White and Whitley.
Office of Medicaid Policy and Planning (OMPP)	The office within the Indiana Families and Social Services Administration that is the designated state agency that administers the Indiana Health Coverage Programs. The OMPP is responsible for developing the policies and procedures for Hoosier Healthwise.
Office of Children's Health Insurance Program (CHIP)	The office within the Indiana Families and Social Services Administration that administers the Children's Health Insurance Program. The CHIP office is responsible for developing the policies and procedures for Hoosier Healthwise Package C enrollees.
PCCM	Primary Care Case Management.
Quality Assurance/ Quality Control (QA/QC)	QA/QC are interrelated methods of monitoring the services that MCOs arrange or administer for its enrollees.
Quality Improvement Committee (QIC)	The committee established by the OMPP that provides oversight for the appropriateness and quality of care provided to enrollees by establishing standards and guidelines for the provision of care. The QIC is responsible for integrating the quality improvement process and services as a coordinating and advisory body.
RBMC	Risk-Based Managed Care.
RHC	Rural Health Clinic—A cost-based reimbursement system of clinics created under the Rural Health Clinic Services Act of 1977 to provide better access to services for people in rural, medically underserved areas through the use of mid-level practitioners
SE	EDS Systems Unit Engineer.

Shadow Claims	Reports of individual patient encounters with a managed care organization's network that contain fee-for-service equivalent detail as to procedures, diagnoses, place of service, billed amounts, and rendering or billing providers.
Southern Region	A Hoosier Healthwise enrollment area in Southern Indiana that includes the following counties: Bartholomew; Brown, Clark, Clay, Crawford, Daviess, Dearborn, Decatur, Dubois, Floyd, Franklin, Gibson, Greened, Harrison, Jackson, Jefferson, Jennings, Knox, Lawrence, Martin, Monroe, Ohio, Orange, Owen, Perry, Pike, Posey, Ripley, Scott, Spencer, Sullivan, Switzerland, Vanderburgh, Vigo, Warrick, and Washington.
TANF	Temporary Assistance to Needy Families for caretakers and children under age 18 years of age that meet eligibility requirements.
Third Party	Any person or entity that is or may be liable to pay for health care and services rendered to an IHCP enrollee. Some examples of third parties include an individual or group plan health insurer, casualty insurer, a health maintenance organization (HMO), or an employer-administered ERISA plan.
Utilization Review (UR)	A process by which the MCO performs ongoing monitoring of the services arranged for and administered by the MCO and provided by its participating providers to ensure that members receive appropriate and medically necessary health care services.

Index

A

ad hoc reports..... 12-3
Agenda Item Request Form B-1
auto assignment 8-1
auto-assignment 8-1
  policy 8-1
  start/stop reason codes 8-10

C

capitation
  adjustments 5-14
  CHIP 7-5
capitation payments
  MCO 5-9
  MCO delivery 5-13
carved-out services 5-29
  dental..... 5-30
  mental health substance abuse..... 5-29
  school corporation..... 5-30
Certification Code Issues E-1
Certification Code Recovery Letter..... D-1
Certification Code Tracking Referral Form..... C-1
certification codes..... 4-6
checklist..... 6-5
Children's Health Insurance Program *3-2*, 7-1
  capitation..... 7-5
  enrollment 7-2
  enrollment rosters..... 7-4
  limitations 7-3
  member eligibility..... 7-2
  provider eligibility 7-3
claim resolution edits/audits 5-21
claimscompound
  prescription drug 5-19
  MCO denied..... 5-19
  shadow 5-18
Claims Resolution Manual..... 9-1
Compound prescription drug claim submission..... 5-19
CSR development 11-2
CSR monitoring..... 11-2

D

delivery capitation payments 5-20
disenrollment 6-1
  checklist 6-5
  MCO 5-6
disenrollment forms and system-generated letters 6-6

E

edits 2017 and 2018..... 5-21
Electronic Claims Capture Manual *9-1*
eligibility redetermination..... 8-12
eligibility, Hoosier Healthwise 3-3
Eligible vs. Enrolled report..... 8-18
enrollment
  MCO 5-2
Enrollment Broker 3-2
enrollment report
  IHCP providers 5-16
enrollment roster
  MCO PMP 5-17

F

File/Tape/Report/Letter—Tracking Table A-1
auto-assignment 8-1
forms
  disenrollment..... 6-6
Forms..... 3-12

G

goals..... 2-1

H

Hoosier Healthwise
  children's health insurance program 3-5
  children's Medicaid 3-5
  pregnancy Medicaid..... 3-4
  TANF 3-4
Hoosier Healthwise program
  IHCP requirements..... 3-7
  MCO network enrollment 3-8
  member eligibility 3-3
  network changes..... 3-9
  package A (standard plan)..... 3-4
  package B (pregnancy coverage) 3-4
  package C (children's health plan) 3-4
  package D (Hoosier Healthwise for persons with disabilities and chronic illnesses) 3-4
  package E (emergency care) 3-4
  panel hold..... 3-10
  panel size..... 3-9

participants 3-1
PMP eligibility 3-7
policy development 3-3
PrimeStep 3-8
provider enrollment 3-6
Hoosier Healthwise program contractors
CHIP office 3-2
Contract Monitor 3-2
Enrollment Broker 3-2
fiscal agent 3-1
MCOs 3-2
medical policy 3-2
OMPP 3-1
Hoosier Healthwise Program Operations–General 3-1
Hoosier Healthwise Program Operations/MCO (RBMC) 5-1
Hoosier Healthwise Program Operations—PrimeStep (PCCM) 4-1
Hoosier Healthwise program participants 3-1

I

IHCP Provider Manual 9-1
Indiana Medicaid Web site 3-12
Information for Researching Certification Code Issues E-1

L

letter to member confirming new PMP/MCO and PCCM 6-17
letter to member of disenrolled PrimeStep/PCCM PMP 6-16
letters
disenrollment 6-6
letters to disenrolling PCCM PMPs 6-14
letters to PMP/MCO PMP disenrollment 6-19
Lock-in 8-14

M

Managed Care Monthly Meeting Agenda Item Submission 2-5
Managed Care Policy 2-4
Managed Care Policy Meeting Agenda Item Request Form B-1
Managed Care Unit Goals 2-1
Managed Care Unit Meetings 2-4
Managed Care Unit Mission 2-1
Managed Care Unit Organization 2-2
Managed Care Unit Overview 2-1
Managed Care Unit Staff 2-2
Managed Care Unit Vision 2-1
manual overview 1-1
manuals
claims resolution 9-1
electronic claim capture 9-1
pricing 9-2
provider 9-1
MCO capitation payments 5-9
MCO contract monitor 5-2
MCO delivery capitation payments 5-13
MCO disenrollment 5-6
MCO enrollment 5-2
MCO Network Enrollment 3-8
MCO orientation 5-5
MCO Orientation 9-1
MCO PMP enrollment roster 5-17
MCO-Denied Claims 5-19
MCOs 3-2
meeting agenda 10-10
meeting minutes 10-9
meetings
documentation 2-6
Managed Care Monthly Meeting Agenda Item Submission 2-5
Meetings 2-4
member assignment 8-12
member disenrollment 8-1
member eligibility, Hoosier Healthwise 3-3
member enrollment 8-1
member reassignment, provider initiated 8-13
mission 2-1

N

network changes 3-9

O

OMPP 3-1
open network changes 3-9

P

Package C 7-1
panel hold 3-10
panel size 3-9
pareto chart 10-3
PMP certification codes 4-6
PMP change criteria 8-12
PMP disenrollment 3-10
PMP disenrollment from Hoosier Healthwise 6-1

PMP disenrollment policy 6-6
PMP disenrollment processing
procedures—internal 6-2
PMP disenrollment/MCO
member letter 6-18
PMP education 3-10
PMP eligibility, Hoosier
Healthwise 3-7
PMP enrollment rosters 4-8
PMP Service Locations 3-9
policy development, Hoosier
Healthwise 3-3
Pricing Manual 9-2
PrimeStep
billing 4-1
covered services 4-1
payment 4-1
PMP administrative fee
payments 4-5
PMP Assignments and Potential
Recipients Tapes 4-4
providers 4-2
reports 4-4
self-referral services 4-2
PrimeStep enrollment 3-8
Prime*Step* overview 4-1
Prime*Step* providers 4-2
eligibility 4-2
PMP disenrollment 4-3
PMP enrollment 4-3
project management 11-1
project task plan mask F-1
Project task plans 11-4
Provider Enrollment in Hoosier
Healthwise 3-6

Q

quality improvement 10-1
key measures 10-5
logs 10-7
processes 10-1

R

RBMC 5-1
Region 22 5-18
reports 12-1
15th of the month 12-3
ad hoc 12-3
eligibile versus enrolled
(Package C) 12-18
eligible versus enrolled 8-18
eligible versus enrolled (Package
A and B) 12-6
IHCP Provider Enrollment 5-16
managed care TPL 12-11
newborn preselect 12-15
PMP enrollment 12-22
QI data grid 12-31
shadow graph 12-37
system generated 12-43
Top 10 shadow claim
denials 12-40
Risk-Based Managed Care 5-1
Risk-Based Managed Care
contractors
enrollment broker 5-2
fiscal agent 5-1

S

self-referral services 5-26
chiropractic 5-27
diabetes self-management
training 5-29
emergency care 5-27
family planning 5-27
HIV/AIDS care
coordination 5-28
podiatry 5-28
vision care 5-28
services
carved out 5-29
related to self-referral and
carved-out 5-30
self-referral 5-26
shadow claim terminology 5-25
shadow claims 5-18
edits and audits 5-21
output documents 5-23
terminology 5-25
shadow claims edits
and audits 5-21
system-generated reports 12-43

T

Third Party Liability reporting 5-16
Tucker Alan, Inc 3-2

U

Unit Task List 11-1

V

vision 2-1

W

Web site 3-12

X

X chart 10-2